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CAMBRIDGESHIRE
EDUCATION COMMITTEE

ANNUAL REPORT

OF THE

Principal School Medical Officer

For the Year 1960

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COUNTY OF CAMBRIDGE

With the Compliments of
the County Medical Officer of Health
& Principal School Medical Officer

SHIRE HALL,
CASTLE HILL,
CAMBRIDGE.

CAMBRIDGESHIRE
EDUCATION COMMITTEE

ANNUAL REPORT

OF THE

Principal School Medical Officer

For the Year 1960

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INDEX

Introduction 4
Annual Eye Tests 22
Athlete's Foot 15
Audiometry 19
B.C.G. Vaccination 24
Deaths of School Children 53
Dental Service 25
Dietary Supplements 13
Diets 14
Educational Psychologist 38
Education Committee, Membership of 7
Educationally Subnormal Children, Survey of 31
Entrants to Training Colleges, Medical examination of 52
Foot Conditions 15
General 10
Handicapped Children 30
Handicapped Young Persons, Employment of 33
Hearing 18
Hygienic Condition of Premises 10
Immunisation and Vaccination 47
Infectious Diseases 46
Malnutrition 13
Meals, Provision of 47
Medical Inspection and Treatment 11
Mental Health Act, 1959 34
Milk, Supply of 47
Minor Ailments 25
Neglect 24
Nose and Throat Defects 16
Nursing Service 45
Obesity 14
Orthopaedic Defects 23
Outward Bound Trust courses 52
Parents, Attendance of 12
Physical Condition 13
Physical Education 48
Plantar Warts 15
Psychiatric Service 35
Recuperative Holidays 13
Screening Tests of Hearing 18
Section 57 of the Education Act, 1944 34
Skin Conditions 15
Special Schools 32
Speech Therapy 42
Squint 22
Staff 8
Swimming Pools 52
Teachers, Medical Examination of 52
Technical College Pupils, Medical Examination of 52
Tonsillectomy 17
Treatment, Proportion requiring 12
Tuberculosis 23
Vaccination and Immunisation 47
Verminous Inspections 46
Vision 21
Appendix I Statistical tables relating to medical and dental inspection and treatment in the rural area 54
Appendix II Statistical tables relating to medical and dental inspection and treatment in the City of Cambridge 60
Appendix III Diet Sheets 68

To the Chairman and Members of the Education Committee.

Ladies and Gentlemen,

Last year my Report envisaged certain changes in the operation of the School Health Service, and I am glad to be able to recount that at the beginning of the autumn term a start was made both in achieving more frequent visits to the schools by the medical staff and in performing annual eye tests on children aged nine to twelve. The routine medical examination at age 11 has been discontinued, children now being examined on entry, at age eight and at about age 13½; a special leavers interview is also arranged for pupils in their final term at school. In the secondary schools the doctors are making weekly or fortnightly visits according to the size of the school. Although the scheme has only been running a short time I am satisfied that the schools appreciate the new arrangements, and I can say with confidence that the medical staff feel that they are now able to give a proper consultative service. The nurses felt some strain initially, but greater familiarity with the working of the scheme has now demonstrated its value.

Since taking up my appointment various changes have been made in the administration of the School Health Service, and it is a pleasure to record the help and encouragement I have received from the Chief Education Officer and from Heads of schools and their staffs. I am particularly grateful to the Wardens of the village colleges and Heads of secondary modern schools for their advice, help and tolerance in the introduction of the new service to their schools; it has truly been the result of team work that the changeover has gone so smoothly.

There are no particular points to which attention should be called regarding the health of the children in the rural area, which remains satisfactory. As the Chief Medical Officer to the Ministry of Education says in his Report for 1958/59 " The great majority of school children were robust and healthy. They were taller, heavier and cleaner than their predecessors. The difference in physique between those from well to do and poorer areas continued to lessen ".

For the second year running Mr. Toller, Principal School Dental Officer, and I have continued to campaign against the national habit of indiscriminate sweet eating. We are fully conscious of the task before us which, in short, is to try to alter a national habit, but we feel that this is so important a matter in the field of public health, and indeed in the national economy, that we must try to arouse public interest and to encourage the adoption of a more intelligent attitude towards the care of the teeth. The fact that at the age of five most children have five or more decayed, missing or filled teeth is a national disgrace. At the other end of school life the ever increasing number of children wearing false teeth only emphasises the ravages of this national, though controllable, epidemic.

On Pages 25 and 26 are given details of the programme of dental health education which has now been going on for rather more than two years. For those who have doubts that any impression can be made, I would say that there is evidence that in the schools children can be made aware of the problem and are prepared to do something about it. It is unfortunate, however, that their efforts are not given greater support by the adult population to whom they inevitably look for example. It should be clearly understood that we are not against the eating of sweets, only that this pleasure should be taken with a modicum of wisdom and not the abandon now prevailing; nor are we against the principle of the tuckshop, only the dentally damaging materials sold there. If people would restrain their sweet eating habits and practice oral hygiene a vast amount of dental disease would be stopped; if in addition the fluoride content of all mains water supplies was adjusted to the optimum level of approximately one part per million then the major part of the problem now before us would be solved.

Physical education is no less important a subject than the three Rs, and in last year's report I welcomed the inclusion of a note by the Organisers of Physical Education about their subject; their further comments are included in this Report. I was very glad to have the opportunity in November of addressing the Cambridge and District Physical Education Club. In that lecture I stressed the very important part physical education has to play in developing the national character. In this connection it is apposite to remark upon the number of children who have once again attended Outward Bound courses. The benefit of these courses cannot be over-emphasised, and I think their content is well epitomised in the Trust's motto " To serve, to strive and not to yield ". The continued building of swimming pools at schools by voluntary effort is most commendable and gives further scope for the physical education of children.

The development of the Family Psychiatric Service, which is based upon the Child Psychiatric Unit of the East Anglian Regional Hospital Board, has continued during the year, but unfortunately at the end of the summer term the Authority's Educational Psychologist resigned and no replacement was obtained before the year's end. This is particularly unfortunate since the Educational Psychologist plays an important part in the prevention, early detection and correction of many mental health problems occurring in schoolchildren. Our present establishment allows for one Educational Psychologist who has to work with two Education and School Health Departments as well as establishing and maintaining liaison with the Child Psychiatric Service which is a most important part of the work and a service of which the appointment is an integral part. The school population to be served is 25,000 situated in 50 schools in the City and 110 in the rural area. The service should cover diagnosis, individual weekly treatment, advice to school and parents, the carrying out of surveys, full reports of all cases, recording and filing, and the maintenance of contact through professional organisations with up-to-date developments and trends in testing and psychological techniques. It will be remembered that when the Regional Hospital Board introduced the Child Psychiatric Service in 1954 in place of the local authority Child Guidance Clinic, the Local Education Authority undertook to provide an Educational Psychological Service as an integral part of the Child Psychiatric Service. From the experience of those professionally engaged in the School Health and Child Psychiatric Services it can be said with confidence that the task is too great for one psychologist and I hope that before long the establishment will be increased.

In September I had the honour of organising, in Cambridge, a refresher course for the Society of Medical Officers of Health: some forty senior school medical officers from various parts of the British Isles attended. The members of the course were greatly appreciative both of the kindness of the Chairman of the Education Committee in taking the chair at a discussion on the future of the School Health Service, and of the Chief Education Officer's very valuable contribution to that lively meeting.

The interest of the Chairman and Members of the Education Committee in our work is a great stimulus and much appreciated; particularly is this so in our dental hygiene campaign.

To all concerned with the running of the School Health Service I record my gratitude for their help and enthusiasm throughout the year.

I am,

Your obedient Servant,

P. A. TYSER,

Principal School Medical Officer.

March, 1961.

CAMBRIDGESHIRE EDUCATION COMMITTEE

(Membership at January, 1961)

The Chairman of the County Council
The Vice-Chairman of the County Council
The Chairman of the Finance Committee

Members of the Council

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Alderman E. W. Parsons‡*
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Councillor E. W. Bullman*
Councillor F. W. Murfitt

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Dr. R. H. Thouless
Mr. B. E. King

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The Ven. H. F. Kirkpatrick
Miss A. H. Skillicorn
Miss M. A. Wileman
Mr. E. T. Glendon*

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Primary Schools	Mr. B. V. Foot*
Secondary Modern Schools	Mr. P. S. Kenyon*
Secondary Grammar Schools	Mr. E. F. Holden
Further Education	Mr. J. L. Tennant

‡ *Chairman of the Education Committee.*
† *Chairman of the Welfare and Canteens Sub-Committee.*
* *Members of the Welfare and Canteens Sub-Committee.*

STAFF

Principal School Medical Officer and County Medical Officer

P. A. TYSER, M.D., B.S., D.P.H.

RURAL AREA

School Medical Officers

J. DRUMMOND, M.B., CH.B., D.P.H., *Deputy Principal School Medical Officer and Deputy County Medical Officer (part-time).*

EILEEN M. BRERETON, M.A., M.B., CH.B.

AMELIE BOYD, B.SC., M.B., CH.B. (*part-time*).

MARIAN E. COEKIN, M.B., B.S. (*part-time*) (*from 24th January until 13th July*).

GWENETH M. GRESHAM, M.B., B.S. (*part-time*) (*from 22nd September*).

Ophthalmic Surgeon

ANNA R. WADE, M.A., M.B., CH.B.

School Dental Staff

J. R. TOLLER, M.SC.D., L.D.S., *Principal School Dental Officer (part-time).*

County Nursing Officer

SARAH MEE, S.R.N., S.C.M., H.V., Q.N., P.H. Admin. Cert.

Lay Administrative Officer

L. BLY, A.C.C.S., D.M.A.

Senior Clerk

R. F. SUMMERFIELD.

CITY OF CAMBRIDGE

(Excepted District)

School Medical Officers

C. G. EASTWOOD, M.D., D.P.H., *City School Medical Officer and Medical Officer of Health.*

MARGARET C. K. PATTERSON, M.B., CH.B., D.P.H., *Deputy City School Medical Officer and Deputy Medical Officer of Health.*

HILDEGARD P. BRODA, M.D. (Vienna).

DOROTHY DAVEY, M.B., CH.B. (*part-time*).

ISOBEL NICHOLLS, M.B., CH.B., D.P.H. (*part-time*).

AMELIE BOYD, B.SC., M.B., CH.B. (*part-time*).

Ophthalmic Surgeon

G. F. Wright, M.A., M.B., Ch.B., D.O.M.S.

School Dental Staff

J. R. Toller, M.Sc.D., L.D.S., *Principal School Dental Officer (part-time).*
Marjorie E. C. Page, L.D.S.
E. Burn, L.D.S.
G. Longhurst, L.D.S. (*from 4th January*).
Juliann Kovesi, L.D.S. (*from 24th October*).
Jessie M. Pountain, L.D.S. (*part-time*) (*until 4th February*).

Speech Therapy Staff for whole of Administrative County

Heather G. Hramtsov, L.C.S.T.
Anna Dutt, L.C.S.T.
Susan Powell, L.C.S.T. (*until 27th November*).
Pamela Emerson, L.C.S.T. (*part-time*) (*from 29th November*).
Lisbeth Levett, L.C.S.T. (*part-time*) (*from 28th November*).

Educational Psychologist for whole of Administrative County

Valerie M. W. Lyall (née James), M.A. (*until 31st August*).

Organisers of Physical Education for whole of Administrative County

Una M. J. Trott, London Diploma of Physical Education.
J. G. Milne, Three Year Diploma of Physical Education, Jordan Hill College of Physical Education, Glasgow (*from 1st May*).

CHILD PSYCHIATRIC SERVICE

(United Cambridge Hospitals and East Anglian Regional Hospital Board.)

Consultant Child Psychiatrist	R. E. Glennie, M.D., D.C.H., D.P.M.
Assistant Child Psychiatrist	B. F. Whitehead, M.A., M.B., B. Chir., D.P.M.
Clinical Psychologist	Miss J. B. Conochie, M.A. (Hons.), Dip. Ed.
Psychiatric Social Worker	Mrs. A. Unvala.
Social Worker and Psychologist	Mrs. S. Abrams, B.A. (Psychology), Certificate of Social Studies (Oxon)
Secretaries	Miss B. W. Hazzard. Miss V. Ling.

GENERAL

The following report on the health of the school children in the rural area during 1960 is submitted in accordance with Section 92 of the Education Act of 1944. The population of the Administrative County is fairly equally divided as between rural and urban areas. The City of Cambridge is an excepted district under the Education Act, 1944. The type of service which can be provided in a scattered rural community with no centre of population over 5,000 persons must differ materially from that which can be developed in an urban area where minor ailment clinics and specialist clinics, for example, can be easily organised. In this report details of the service in the rural area are given and commented upon. Figures for the results of the service in the City are given as an appendix (both rural and urban area figures are consolidated for forwarding to the Ministry), but comment upon the details of the City service are usually given as a part of the Annual Report of the City Medical Officer of Health.

At the end of 1960 there were 101 Primary Schools (including one Nursery School), 10 Secondary Modern Schools (one with Grammar School stream), and Soham Grammar School, in the rural area of the Local Education Authority.

In January 1961 the number of children on the registers of Primary and Secondary Schools was 11,632. There were also 383 boys on the register at Soham Grammar School who form part of the total number under consideration in the paragraphs which follow.

HYGIENIC CONDITION OF PREMISES

The policy of closing small, out of date schools was continued in 1960. Harlton and Toft Schools closed at the end of 1959, and Ickleton, Hinxton, Reach and Kingston Schools during 1960.

The new school at Duxford was opened, and work continued on the Burwell C.E. School which is expected to be ready about Whitsun 1961.

Additional classrooms were completed at Bottisham Primary School, Sawston Village College, Swavesey Village College and Barrington School, the latter including lavatories.

New sanitary accommodation was provided at Burrough Green, Dullingham and Fen Ditton Schools, and mains water installations were completed at Pampisford and Odsey.

The school medical officers continue to make enquiries about hygienic conditions in schools at the time of their visits, and the Chief Education Officer is kept informed of the matters brought forward.

MEDICAL INSPECTION AND TREATMENT

It was not found possible to appoint an additional full-time Assistant Medical Officer to complete the establishment. Dr. Boyd's part-time appointment was, therefore, continued and she worked for four sessions per week in the first two terms and for six sessions per week in the winter term. Dr. M. Coekin was employed for two sessions per week for the first half of the year, and was succeeded in the winter term by Dr. G. M. Gresham who is being employed for three sessions per week.

Dr. Brereton continued to work full-time and Dr. Drummond part-time in the School Health Service.

The re-organisation of the School Health Service mentioned in the 1959 Report began at the beginning of the winter term. As a first step the routine examination of the eleven years old child has been discontinued, children being fully examined on entry to school, at age 8 and at age 13½, with an interview with a medical officer prior to leaving school. Children found to have defects will continue to be re-inspected at frequent intervals.

The arrangements in force for the Village Colleges have been altered to allow of more frequent visits by members of the medical staff. Each secondary modern school is now visited once a week or once a fortnight, according to size. The usual routine examinations and re-inspections are carried out at these visits, but at the same time teachers and parents have greater opportunities of obtaining the advice of the medical staff as and when the need arises.

The arrangements for the primary schools remain unchanged, routine medical inspections being carried out at approximately six-monthly intervals, with informal visits being paid so that each school is visited at least once a term. In many cases it has been possible to increase this to two visits a term. It is intended that the system of frequent visits now in operation at secondary modern schools shall eventually be extended to all schools, and it is hoped in the near future to introduce it to the larger primary schools.

The following figures show the number of inspections carried out in 1960, with figures in parenthesis for 1959:

Routine inspections	4,138	(4,584)
Special inspections (including 542 leavers interviews)	682	(534)
Re-inspections	4,310	(4,517)

Detailed figures relating to school medical inspections, set out in the form required by the Ministry of Education, are shown at the end of the Report.

Attendance of Parents

The following table shows the proportion of parents attending routine medical inspections.

Year of birth	Number of children examined	Number of parents attending	% of parents attending
1956 and later	70	57	81.4
1955	868	702	80.9
1954	363	293	80.7
1953	301	227	75.4
1952	733	487	66.4
1951	242	163	67.4
1950	58	38	65.5
1949	84	35	41.7
1948	82	9	11.0
1947	88	6	6.8
1946	872	48	5.5
1945 and earlier	377	14	3.7
TOTAL	4138	2079	50.2

In the previous year 55.2% of parents attended routine medical examinations.

Proportion of Children requiring Treatment

The following table shows the proportion of children found to require treatment for defects other than dental disease or vermin at routine medical inspection over the last ten years:

1951	19.3%	1956	12.4%
1952	13.9%	1957	12.4%
1953	12.1%	1958	12.4%
1954	13.7%	1959	14.7%
1955	14.6%	1960	21.5%

It will be noted that there is a considerable increase in the proportion of children routinely examined who were considered to require treatment, 21.5% in 1960 as opposed to 14.7% in 1959 and 12.4% in the three preceding years.

Examination of the statistics shows that there has been no increase in the total number of defects found in 1960. Defects were found in the ratio of ten defects to every fourteen children examined in both 1959 and 1960. In 1959, however, ten children in every 68 examined were referred for treatment, while in 1960 the ratio was 10 in 46.

I have discussed these facts with my colleagues and we are unable to offer any simple answer in explanation of the increased number of children with defects considered to require treatment. It is a well established fact that different observers in objective studies will vary considerably in their assessment of a characteristic; there is no doubt that this factor has operated over the year. The changes made in the organisation of the School Health Service may also have played a part; further, it is possible that some observers may have a particular interest in one or more defects and be paying special attention to their detection and treatment. Whatever may have been the factors leading to the results obtained I am confident that it does not reflect in any deleterious way upon the good standard of our children's health; rather perhaps it reflects the meticulousness of the doctors' care in endeavouring to see that every child is enabled to develop to its full potential.

Physical Condition

A. The following table compares the proportion found to have unsatisfactory physical condition in 1960, with previous years:

Year	Number of periodic inspections	Unsatisfactory physical condition	%
1951	4010	68	1.69
1952	4316	25	.58
1953	4166	7	.17
1954	4225	9	.21
1955	4668	8	.17
1956	4975	32	.64
1957	5115	24	.47
1958	5509	20	.36
1959	4584	57	1.25
1960	4138	33	.80

As has been mentioned in many reports these figures require careful interpretation. The general condition of the children in the County is good and forms a sound basis upon which the organisers of physical education can plan their curricula.

B. The supply of cod liver oil and malt was discontinued during the early part of 1960. At the end of the year the undermentioned dietary supplements were being supplied to the number of children shown:

Maltoline with iron	237
Vitamin C Tablets	6
Vitaminor Capsules	5
Ostocalcium Tablets	5

These figures compare with 141 children in receipt of cod liver oil and malt at the end of 1959.

C. One child was sent to an open air school for a two months' stay.

D. For some years now the medical staff have been concerned by the increase in the number of fat children seen at medical inspections. It is apparent that the under nourishment of the pre-war days is now being replaced by another form of " malnutrition " which, in the long view, would be just as dangerous. There are several problems, however, which make treating this disorder particularly difficult and often unsatisfactory, namely,

(1) The failure or reluctance of the parents and child to recognise the need for treatment.

(2) The reluctance of parents to recognise that glandular disfunction plays only a very small part in obesity and that by far the greatest number of cases is due to simple over-eating.

(3) The initial discomfort of restricting food intake when a large intake is the normal habit.

(4) The loss of the psychological comfort of eating when this is a compensation for unhappiness or failure in physical activities.

(5) The apprehension that many parents feel about restricting a child's intake of food coupled with possible feelings of guilt that such restrictions cast aspersions on their ability to provide for their children.

As a first step to systematically combating this problem diets of 1,000 and 1,500 calories were drawn up by the Dietitian Catering Officer for Addenbrooke's Hospital (Appendix III) and these have been given to those children where it appears that a determined attempt to follow the diet was likely to be made. At the same time the school was asked to weigh these children regularly and the record is studied when the child is next seen at re-inspection. It is essential for the success of any dieting that the re-inspection be at fairly frequent intervals as these children are greatly in need of encouragement and reassurance.

We gratefully acknowledge the help that the Dietitian Catering Officer has given us in the preparation of these charts and for giving permission for their free use.

During lectures given by the School Doctors to Physical Education Teachers it was evident that they too had noticed, and were worried about, this growing problem. It was stressed to the Teachers that they need not worry about overworking an obese child, but that they would have little success with the child if, in this connection, his fatness was going to make him the target for ridicule. The importance of fat children competing against their own previous standards and not against the rest of the class is paramount, for it is essential that they are able to see a positive result for the efforts made. The use of specialised exercises so that an obese child may try to develop strength rather than agility has also been suggested.

The importance of obesity as a community disease in an affluent society and its relationship with coronary arterial disease in middle age is becoming well recognised. Every effort must be made in prevention and treatment from the earliest age, particularly as children today are subjected ceaselessly to the most compelling advertisements urging them to eat more and to eat more frequently; even during school hours the opportunity to eat more is afforded to them by the presence of the school tuck shop.

Skin Conditions

A. Skin conditions found at periodic medical inspections during last ten years:

Year	Number of periodic inspections 1	Found to require treatment 2	For observation only 3	Total 4	Col. 4 as percentage of Col. 1
1951	4010	57	173	230	5.7
1952	4316	37	115	152	3.5
1953	4166	80	90	170	4.1
1954	4225	64	125	189	4.5
1955	4668	77	123	200	4.3
1956	4975	55	87	142	2.8
1957	5115	54	108	162	3.2
1958	5509	45	83	128	2.3
1959	4584	59	107	166	3.6
1960	4138	80	82	162	3.9

B. 45 children are known to have received treatment for skin conditions during the year.

The School Health Service referred five children to Addenbrooke's Hospital for skin conditions.

C. Contagious diseases in schoolchildren were notified as follows:

	1960	1959	1958
Scabies	2	4	5
Impetigo	25	23	15
Ringworm (body)	7	8	2

D. During the year I visited a number of schools in order to witness some part of the physical education programme. I found there was some concern over the question of the spread of plantar warts and fungus infection of the toes in relation to bare foot work, a feature of physical education programmes much to be commended. It seemed appropriate that definite advice based upon current knowledge should be given, and the following note was made available for circulation:

" The two commonest foot infections that concern physical educationalists, are plantar warts and what is called athlete's foot.

True athlete's foot is caused by a fungus infection and diagnosis can only be established by microscopic examination of scrapings from the site of the lesion. It is a fact that many people suffer a maceration of flesh between their toes, in which no fungus can be detected. It is therefore impossible by clinical inspection of a person's feet, to determine whether or not they actually have a fungus infection. Transfer of the fungus from one person to another is not easy, and can only take place by fragments of infected skin coming into contact with the skin of another person's foot.

With regard to plantar warts, recent work has shown that the occurrence of plantar warts is only a manifestation of a general wart infection in the community, and to control plantar warts (if this is possible at all) would necessitate some form of control of all persons suffering from warts in the community.

The advent of barefoot activity in physical education is to be applauded, but it is unfortunate that this activity is often curtailed because teachers of physical education believe that one of the class is suffering from one of the conditions I have mentioned, and in order to prevent spread, rule that all the children in that class should wear shoes.

Recent work has shown that the most likely place for spread to take place is in shower baths and changing rooms. It has also been shown that the frequent swabbing of these surfaces is the best method of control. Similarly the swabbing of gymnasia floors should be practised.

I would suggest, therefore, that in the County as a whole, the policy to be adopted is the frequent swabbing of shower bath and changing room floors and also of gymnasia floors, and that barefoot activity be encouraged, where floor surfaces are suitable, and that unless a child presents itself with a doctor's certificate stating that barefoot activity should not be indulged in because of an infectious condition, that physical education teachers do not concern themselves with inspecting children's feet viz a viz infectious foot conditions."

Nose and Throat Defects

A. Nose and throat defects found at periodic medical inspections during last ten years:

Year	Number of periodic inspections 1	Found to require treatment 2	For observation only 3	Total 4	Col. 4 as percentage of Col. 1
1951	4010	52	398	450	11.2
1952	4316	50	297	347	8.0
1953	4166	44	275	319	7.6
1954	4225	35	216	251	5.9
1955	4668	50	245	295	6.3
1956	4975	40	258	298	6.0
1957	5115	38	174	212	4.1
1958	5509	35	272	307	5.6
1959	4584	60	352	412	8.9
1960	4138	58	240	298	7.2

B. The following table relates to the number of children noted at routine medical inspection during 1960 to have undergone tonsillectomy.

Boys				Girls			
Year of birth	No. Examined	No. had tonsillectomy	%	Year of birth	No. Examined	No. had tonsillectomy	%
1956 and later	44	–	—	1956 and later	26	1	3.8
1955	448	15	3.3	1955	420	14	3.3
1954	184	9	4.9	1954	179	6	3.4
1953	155	15	9.7	1953	146	17	11.6
1952	354	53	14.9	1952	379	38	10.0
1951	144	25	17.3	1951	98	13	13.3
1950	33	5	15.1	1950	25	3	12.0
1949	42	10	23.8	1949	42	5	11.9
1948	63	13	20.6	1948	19	3	15.8
1947	52	17	32.7	1947	36	4	11.1
1946	489	91	18.6	1946	383	61	15.9
1945 and earlier	245	50	20.4	1945 and earlier	132	27	20.5
Totals	2253	303	13.5	Totals	1885	192	10.2

The following table compares the total number of children found in 1960 to have had tonsillectomy with previous years:

BOYS				GIRLS			
Year of Examination	No. Examined	No. had tonsillectomy	%	Year of examination	No. Examined	No. had tonsillectomy	%
1957	2706	335	12.4	1957	2409	283	11.7
1958	2954	401	13.6	1958	2555	298	11.7
1959	2472	306	12.4	1959	2112	224	10.6
1960	2253	303	13.3	1960	1885	192	10.2

C. Number of children known to have received treatment during the year. Figures for 1959 in parenthesis.

Operative treatment:		
Tonsillectomy	182	(178)
Other nose and throat conditions ..	16	(4)
Ear conditions	13	(6)
Non-operative treatment	52	(47)

The School Health Service referred 42 children to E.N.T. clinics during the year (18 in 1959). The increase in referrals results mainly from the ascertainment of cases of hearing loss by routine audiometry.

Hearing

A. The following table relates to the number of cases of defective hearing found at routine medical inspection in the last ten years.

Year	Number of periodic inspections 1	Requiring treatment 2	For observation only 3	Total 4	Col. 4 as percentage of Col. 1
1951	4010	11	50	61	1.5
1952	4316	8	33	41	.95
1953	4166	8	40	48	1.2
1954	4225	12	40	52	1.2
1955	4668	6	39	45	.96
1956	4975	14	53	67	1.3
1957	5115	12	39	51	1.0
1958	5509	12	66	78	1.4
1959	4584	23	65	88	1.9
1960	4138	48	60	108	2.6

B. The importance of early ascertainment of deafness in children cannot be over-emphasised. Loss of hearing can be detected by tests from the age of seven months, and it is also at this period that special training should be begun if a significant hearing loss is present. Five health visitors in the rural area (and a similar number in the City) have been trained in the early detection of deafness. This represents but a small start in the programme to counteract this defect. In April 1961 a further twelve health visitors are to be trained, and as far as possible their efforts will be directed to those children who are particularly at risk, for example where there is known deafness in the family, where the mother is known to have had rubella in the first three months of pregnancy, prematurity and prolonged labour.

The following table sets out the results of screening tests carried out by health visitors in the rural area during 1960.

Year of Birth	Number of children tested			No. with hearing defect	
	BOYS	GIRLS	TOTAL	BOYS	GIRLS
1960	19	22	41	—	—
1959	49	34	83	1	—
1958	7	11	18	—	—
1957	2	—	2	—	—
1956	3	1	4	—	—
Totals	80	68	148	1	—

The boy with hearing defect was referred to his general practitioner, who arranged for him to attend Addenbrooke's Hospital out-patients.

C. Routine testing of seven year old children with a pure tone audiometer was carried out in all primary schools in the rural area. In addition, schoolchildren of all ages specially referred on account of suspected hearing loss were examined, as were children thought to be educationally subnormal. The following tables detail the results of the tests.

(I) Routine testing of seven year olds.

Year of Birth	Number tested		Passed		Failed right		Failed left		Failed both	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
1954	122	129	115	127	3	1	3	—	1	1
1953	391	401	383	389	3	3	2	2	3	7
1952	367	409	352	388	3	3	7	9	5	9
Totals	880	939	850	904	9	7	12	11	9	17

(II) Tests specially requested.

Year of Birth	Number tested		Passed		Failed right		Failed left		Failed both	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
1955	12	6	6	4	1	—	1	—	4	2
1954	27	12	20	9	1	—	—	—	6	3
1953	25	13	17	12	2	—	4	—	2	1
1952	14	13	11	10	1	1	1	—	1	2
1951	32	18	26	16	3	1	1	1	2	—
1950	15	10	13	7	1	1	—	1	1	1
1949	12	2	10	2	—	—	1	—	1	—
1948	6	4	4	3	1	—	1	—	—	1
1947	2	6	2	4	—	—	—	1	—	1
1946	8	5	5	4	1	1	2	—	—	—
1945	5	5	5	1	—	2	—	2	—	—
1944	1	—	1	—	—	—	—	—	—	—
Totals	159	94	120	72	11	6	11	5	17	11

(III) Re-tests of children failing on first examination.

Year of Birth	Number tested		Passed		Failed right		Failed left		Failed both	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
1955	4	2	1	1	—	—	1	—	2	1
1954	24	6	6	2	—	1	2	1	16	2
1953	32	17	21	8	7	4	1	2	3	3
1952	31	37	21	28	1	3	2	2	7	4
1951	24	15	10	10	5	4	1	—	8	1
1950	28	6	17	4	6	—	1	—	4	2
1949	15	6	12	4	2	1	—	—	1	1
1948	4	4	3	1	—	2	1	1	—	—
1947	—	2	—	—	—	—	—	2	—	—
1946	1	2	—	—	—	2	1	—	—	—
1945	—	4	—	3	—	1	—	—	—	—
Totals	163	101	91	61	21	18	10	8	41	14

When this service was started last year, mention was made of the high failure rate in the routine testing of seven year old children (18.8%). While it is true that many schools do not have suitable accommodation for the carrying out of these tests, the failure rate in 1960 has been reduced to 3.6% of the total routine examinations, no doubt due to the fact that the audiometrician is now more experienced in the work. A higher proportion of children specially referred were found to fail the first test (24.1%). This is, of course, to be expected as most of them were referred by medical officers or teaching staff as children who appeared to have defective hearing.

Of the children failing to pass on first examination, 264 were retested during the year (this total includes cases carried forward from the previous year). 152, or 57.6%, were found on retest to have no hearing loss, and of the remainder 33 were referred to hospital clinics, 10 to general practitioners, 20 were known cases considered to require no immediate action and the remainder are to be retested after six or twelve months.

Of the ten cases referred to general practitioners, it is known that five were referred to hospital out-patients where three were found to have no hearing loss. The remaining two had slight hearing loss, and were taken on for treatment. Of the other five cases referred to general practitioners two were reported to be under treatment at the end of the year, one had left the area and the other two were not considered by the family doctor to require treatment.

Of the 33 cases referred to hospital out-patient clinics, 26 had been seen by the end of the year. Sixteen were found to have slight hearing loss, twelve being considered to require treatment. Two children had severe deafness in one ear only for which treatment would be of no help, and eight children were found to have normal hearing. Five cases, referred towards the end of the year, were not seen during 1960, and two children left the area.

None of the children tested had a hearing loss of such a nature that special educational treatment would be required.

Defective Vision and Squint

A. The following table shows the number of cases of defective vision (excluding squint) found at periodic medical inspection for past ten years:

Year	Number of periodic inspections 1	Requiring Treatment 2	For observation only 3	Total 4	Col. 4 as percentage of Col. 1
1951	4010	210	435	645	16.1
1952	4316	184	548	732	16.9
1953	4166	170	465	635	15.2
1954	4225	186	470	656	15.8
1955	4668	236	513	749	16.1
1956	4975	250	565	815	16.4
1957	5115	245	609	854	16.7
1958	5509	293	679	972	17.6
1959	4584	162	571	733	16.0
1960	4138	220	321	541	13.7

B. Cases of squint found at periodic medical inspection during last ten years:

Year	Number of periodic inspections 1	Requiring treatment 2	For observation only 3	Total 4	Col. 4 as percentage of Col. 1
1951	4010	26	70	96	2.4
1952	4316	11	65	76	1.8
1953	4166	1	70	71	1.7
1954	4225	7	78	85	2.0
1955	4668	25	80	105	2.3
1956	4975	16	86	102	2.1
1957	5115	17	84	101	2.0
1958	5509	15	113	128	2.3
1959	4584	19	83	102	2.2
1960	4138	26	35	61	1.5

C. Mention was made in the 1959 Report of the proposal to institute annual eye tests by the school nurses. This scheme, involving children aged nine to twelve, was started in September. The following table shows the results of the tests:

Year of birth	Number tested			Number failed		
	Boys	Girls	Total	Boys	Girls	Total
1952	34	38	72	5	5	10
1951	409	354	763	41	41	82
1950	385	230	615	35	32	67
1949	383	299	682	21	29	50
1948	387	308	695	22	23	45
1947	41	41	82	4	3	7
1946	2	1	3	—	—	—
TOTAL	1641	1271	2912	128	133	261

The children who fail the tests carried out by the nurses are referred to the medical officers for examination at school medical inspection, and by the end of the year 122 children had been examined. Of this number the medical officers considered that 97, or 79.5%, had a defect of vision. Sixty have been referred to eye specialists, and the remaining 37, who are not considered to require treatment at present, are being kept under observation at school medical inspection. The proportion of children found to have visual defects indicates the value of the tests carried out by the nurses.

D. The following tables relate to children referred by the School Health Service to Dr. A. R. Wade for the examination of eyes.

No. of Children Examined		
Old Cases	New Cases	Total
417	282	699

Treatment Recommended						
Glasses prescribed first time	Lenses changed	To continue present glasses	Glasses discontinued	Orthoptic treatment	Other treatment	No treatment
141	233	128	21	11	19	149

Defects Found—New Cases Only					
Myopia	Squint	Astigmatism	Hypermetropia	Other Defects	No Defects
88	29	4	31	17	113

In addition to cases seen by Dr. Wade, the School Health Service referred 57 children to the eye clinics at Addenbrooke's Hospital and Newmarket General Hospital and the Ely Eye Clinic. It is known that 232 children attended the hospital departments or were seen under the general arrangements of the National Health Service, and that glasses were prescribed for 117.

Orthopaedic Defects

Thirty nine children are known to have attended hospital orthopaedic clinics during the year (21 in 1959, 23 in 1958).

The School Health Service referred 6 children to Addenbrooke's Hospital orthopaedic clinic.

Tuberculosis

A. One child suffering from pulmonary tuberculosis was admitted to an institution during 1960, and was discharged before the end of the year.

B. Incidence of tuberculosis in children aged 5-14:

Year of notification	Pulmonary	Non-pulmonary	Total
1951	3	8	11
1952	1	4	5
1953	7	3	10
1954	1	8	9
1955	1	2	3
1956	1	4	5
1957	6	1	7
1958	1	2	3
1959	4	—	4
1960	2	—	2

C. The scheme to offer B.C.G. vaccination to children aged 13 years and over, which was commenced in 1959, was continued in 1960 and is now an annual feature of the services provided by the local health authority.

The following table sets out the results of the work of the B.C.G. team in the rural area:

Number skin tested (multiple puncture test) ..	1,498
Number found positive	324
Number found negative	1,136
Number vaccinated	1,102

Of the number found to give a positive reaction to skin testing, 194 were X-rayed at the Chest Clinic before the end of the year. One boy was found to have a tuberculous infection, thought to be inactive, and he will be kept under observation.

In addition to those mentioned above, a number of children received B.C.G. vaccination at the Chest Clinic under the Contacts Scheme.

Neglect

Seven families were referred to the N.S.P.C.C. for the following reasons:

Failure to keep appointments at eye clinic ..	3
Failure to obtain spectacles	1
Failure to obtain dental treatment	1
General neglect	2

Other Defects

In addition to the foregoing sections, the following treatments are known to have been received:

Appendicectomy	32
Circumcision	3
Herniotomy	7
Minor Ailments	144

The School Health Service referred children to hospital clinics (excluding the Child Psychiatric Service) as follows:

Enuresis	9
Asthma	2
Undescended testicles	2
Heart condition	1
Hydrocephalus	1
Suspected epilepsy	1

SCHOOL DENTAL SERVICE

(1) General

There was no change in the staffing position in 1960. Against an establishment of 3½ dentists for the rural area, only the part-time services of Mr. Toller, the Principal School Dental Officer, were available. As in the previous year he worked in the Shire Hall Dental Clinic for one session per week for emergency work, and for the remaining mornings in the mobile dental clinic at schools. It is only possible for Mr. Toller to visit a small number of schools in each year, and he therefore concentrates on visits to the larger schools.

The figures again show a reduction in the number of children inspected (1,629 in 1960, 2,479 in 1959). 1,305 children were considered to require treatment, or 80.1%, as against 75.7% in 1959 and 64.6% in 1958.

Treatment was offered to 1,203 children or 92.2% of those requiring it (63.7% in 1959, 49% in 1958).

Of those offered treatment 764, or 63.5% were actually treated (79.5% in 1959).

Detailed figures of the work of the School Dental Service appear at the end of the Report, the rural area figures being under Part IV of Appendix I, and the City figures under Part IV of Appendix II.

(2) Dental Hygiene Campaign

A dental hygiene campaign was instituted in 1959, and continued during 1960. The following notes set out briefly the various stages of the campaign.

The first step was to ensure that the local dental practitioners were aware of the serious position of the School Dental Service, particularly in the rural area, and in January 1959 I had a discussion with the Secretary of the local branch of the British Dental Association. As a result of that discussion I wrote to all dental practitioners in the area asking for their co-operation in sparing as much time as possible for the treatment of children's teeth. This was followed by a letter to the Heads of all schools in the rural area explaining the position and asking them to advise parents to seek dental treatment for their children otherwise than through the School Dental Service.

In September 1959 a poster was issued to primary and infants' schools, the theme being that of the advisability of eating fruit rather than sweets.

A memorandum entitled " The Effect of Civilised Foods on Teeth " was produced by Mr. Toller and issued to all schools in January 1960. At the same time there was some general and local press publicity, as well as a television appearance by Mr. Toller.

In September 1960 a booklet entitled " Dental Health " was sent to every teacher in the rural area. The booklet covered various aspects of dental health, and was intended to assist teachers in the task of making the children and their parents dentally conscious and responsible.

About a month after the issue of the booklet to the teachers, 12,000 leaflets on the care of children's teeth were sent to the rural area schools for distribution to all children. At about the same time details of the campaign were sent to the local daily and weekly newspapers, certain medical and dental journals, and the regional television station.

Towards the end of the year a film was procured on loan from the National Farmers Union, relating to the beneficial effect of apples on teeth, and was shown in a number of schools.

It is intended that the next step, early in 1961, shall be the issue to all schools of the admirable posters issued by the Oral Hygiene Service (a private organisation), together with their booklet " Teaching Dental Health ". The latter contains three lectures on dental hygiene which should be of great help to the teaching staff.

Report of the Principal School Dental Officer

I am indebted to Mr. Toller for the following report:

" There has been no increase of dental staff during 1960. The Principal School Dental Officer, half of whose time is devoted to the Excepted District of the City of Cambridge, remained the only dentist for the rural part of the County, which therefore still has, in effect, a ratio of one dentist to 24,000 children.

It is pleasant to be able to add a little on the credit side though it is intangible and does not balance the solid fact in the first paragraph. Following the submission of a memorandum on dental health to the Education Committee in March 1960, positive directions on dental health education were given to the Principal School Medical Officer and Principal School Dental Officer. With the co-operation of the Chief Education Officer, a booklet " Dental Health " and a leaflet of dental " do's " and " don'ts " for parents were produced by the county Printing Department. The booklet was distributed to every teacher in the rural part of the county in September and the leaflet to all parents (via their children) in October. At the time of writing teaching material supplied by the Oral Hygiene Service (a voluntary organisation) is being distributed to the schools. A short account of our activities was published in the British Dental Journal, 7th February, 1961.

A perceptible climate of opinion is being created locally. Parents and children are becoming increasingly aware of what can be done to mitigate the pestilence of dental disease and the burden of its treatment by preventing a substantial amount of it. Children are beginning to be aware of their eating habits and to feel guilty where they have been made to feel that they fall short of what they should be. They are giving the healthy maintenance of their dental apparatus more thought. More children are seeking and receiving regular dental treatment in the National Health Service, though this source of treatment must now have reached saturation point and the amount of treatment that can be given by an ageing and diminishing dental profession must in future decrease.

It is sad that when children are doing more to help themselves to prevent dental disease less help by dentists will be available to them to repair the disease that will arise in spite of their effort to prevent it. It is with pleasure that I read the official reports of the proceedings of the legislature of the Irish Republic which has given their country the distinction of being the first to make the fluoridation of public water supplies compulsory.

For the six years previous to 1958 I ate a school dinner, usually with the children, every school day. It always appeared to me to be strange that local education authorities, collectively the largest single caterers in the country, should in practice pay so little attention to the necessity of mouth cleaning at schools after meals. A little obvious official preoccupation with this elementary social aesthetic and health chore at school would, I think, do more good than talk about its wisdom in class, unsupported by practical example. With the present price ceiling on the cost of food per meal, of necessity the cheaper sources of fuel must be used and carbohydrates (of which children receive in general a sufficiency elsewhere) preponderate more than they should, making mouth cleaning after meals very desirable. All school dentists remark how sometimes it is impossible to examine teeth after the mid-morning biscuit; it is equally impossible, sometimes, after the school pudding. I feel that it is time that dental interest was represented in the formulation of the policy governing school meals at both the national and local level.

Mouth cleaning at school is, practically, very difficult, often impossible. A few determined children could, and some do, clean their mouths with a brush at schools where plumbing facilities allow this, but no suitable cheap hygienic holder in which to carry a brush has yet been devised. Children who use brushes want toothpaste, which presents an added difficulty in solving the problem of teeth cleaning at school. Much could be achieved by using one's own muscles, the tongue and cheeks, as a cat or dog does after feeding, but parents do not seem to teach their infants this exercise, the use of which (in private) should be encouraged. Mouth rinsing with the dinner table water is valuable, but unless children are taught how to do so within social bounds by their parents I do not see how it could become general at schools. Very few children, or adults, know how to rinse their mouths. I do not feel that teachers should be expected to teach these elementary personal chores. These are matters that would best be dealt with by a peripatetic dental hygienist.

The only practical toothbrush at school is a natural one—an apple. The obstacle to its use is its cost. An apple for each child at the end of the school meal, in the rural part of the County, would cost about £10,000 per annum. This is clearly beyond local resources, and active negotiations on a national level are taking place at the time of writing to provide ' natural toothbrushes ' to terminate school meals. Over three million school meals are eaten each school day in England and Wales, and the cost of providing an apple with which to terminate them would be £3,000,000 a year. Since there is a 20% purchase tax on toothbrushes and dentifrices, the principal means by which individuals can decrease the amount and rate of their dental disease, it is suggested that a 20% tax on sweets and chocolate, a principal means by which individuals can increase their dental disease, might pay for the apples—and the school dental services. Nearly all dental disease is repaired at public cost. Meanwhile there is nothing to prevent parents providing their children with apples to take to school—they are easy and clean to carry about. I am glad to report that many schools in the County are selling apples to children instead of dentally dangerous commodities.

To indicate how little we care for our teeth two facts are relevant. Twenty-five million toothbrushes are sold annually in this country; 140,000,000 is the number that should be sold allowing every potential user four each year. We eat 29 lbs. of apples each a year, less than half the average for Europe.

The National Farmers Union kindly lent me for three months their copy of the dental health film " Gateway to Health ". It is a sound-colour film of twenty minutes duration. It is directed at adolescents and adults and is devoted mainly to the value of apples as natural toothbrushes. It was circulated through the village colleges, each of which was given its unrestricted use for a period. In one of the major fruit growing areas of the country the dental value of our own produce should be appreciated.

I should like to thank the local press for their notice of our activities and for their responsible regard for the problem of dental disease; their help is appreciated and is of great value.

The City of Cambridge

(*Excepted District*)

An additional dentist joined the staff on January 1st, 1960. Welcome as the additional dentist is, this appointment raised the average age of dentists on the staff. In November 1960 a young dentist joined the staff, but resigned before the end of the year.

A further serious obstacle to recruitment has arisen and is relevant to the last appointment. The Royal Commission on the Remuneration of National Health Service Doctors and Dentists, whose report was published during 1960, has apparently accepted the principle that National Health Service general dental practitioners should receive their highest remuneration (as indeed they do) while young, and that their remuneration should taper off as energy flags with age, as indeed it does. I forebear to state where the principle leads if applied more generally in other professions. A young dentist now feels officially entitled to the largest income he will ever receive immediately he qualifies, but in the School Dental Service must begin at the bottom of the scale and be offered less than half what he can earn in the National Health Service. It is obvious that some rather fundamental organisational and administrative changes are desirable in our profession.

I am disturbed however by the falling output of our school dentists. In the country as a whole the output of school dentists has been consistently falling over the last decades and the fall is not wholly explained by the increasing age of full time dentists and the vast increase of part time school dentists. Perhaps the explanation is that there are now no competitive, energetic, enthusiastic young dentists entering the service, burning with righteous indignation at the state of our children's teeth and consumed by a missionary zeal to improve them. There used to be once. There were over a hundred applications for the vacancy for a dentist advertised immediately before the last war in the School Dental Service of Cambridge. When we advertise now we are lucky to get one applicant and usually get none.

Following the submission of a memorandum on dental health to the City Committee for Education which received considerable discussion, the following resolution (inter alia) was passed on 23rd February, 1960:

> That tuck shops be discouraged in primary and secondary schools other than at those secondary schools attended by children who must leave home very early in the morning.

When it was reported to the Committee on 8th November, 1960, that of the seventeen schools who had tuck shops fifteen had taken no action and two some, the following resolution was passed:

(1) That the list, prepared by the Principal School Dental Officer, of food stuffs least harmful to children's teeth, be forwarded to all schools and that Head Teachers be requested to limit their sales to commodities on this list.

(2) That the matter be further reviewed in six months time.

It is anticipated that a more satisfactory report of action taken by Head Teachers as a result of this resolution will be made than could be made following the first resolution. It is significant that over thirty schools manage without tuckshops at all. I am glad to be able to say that the general remarks made in my report on the rural part of the County regarding the favourable change in the attitude to feeding habits and oral hygiene are equally applicable to the City of Cambridge where practices which would not have been tolerated in the days of Mr. Sedley Taylor and Mr. Cunningham. fifty years ago, were becoming e nerally accepted."

J. R. TOLLER.

HANDICAPPED CHILDREN

(1) Special Educational Treatment for Educationally Subnormal Children

I mentioned in my Report for 1959 the difficulty experienced in the rural area in providing special education for all educationally subnormal children. Special consideration has been given to this problem during 1960.

One factor in the situation has always been the shortage of places at special schools for the educationally subnormal, especially so far as boys are concerned. During 1960 the completion of the Lady Adrian School in Cambridge resulted in a welcome increase in the number of places available for day pupils from the rural area. In the first instance the allocation of places was increased from ten to twenty, but as it did not prove possible to fill immediately all the remaining vacancies with children from the City a further ten places have been allocated temporarily to the rural area, making at the end of 1960 a total of 30 rural area children in attendance. Despite this increase in the number of day pupils, and the admission of 12 children to residential schools during the year, there were 17 children on the waiting list at the end of 1960 (10 for the Lady Adrian School and 7 for residential schools).

Another factor which affects the position is the reluctance of many parents to allow their children to attend residential schools, and in a rural area there is the difficulty and expense of providing transport for children from a wide area to attend as day pupils.

In order to get some idea of the size of the problem, a survey was carried out in the early months of 1960. Heads of all primary schools in the rural area were asked to give details of children aged between eight and eleven whom they considered to be in need of special educational treatment, and a total of 205 names was submitted (147 boys and 58 girls). These children have been examined by the medical staff, and the following tables detail the results of their examinations.

(I)

*Intelligence Quotients of Children Examined

I.Q.	Born 1947		Born 1948		Born 1949		Born 1950		Born 1951		Born 1952		Totals	
	B	G	B	G	B	G	B	G	B	G	B	G	B	G
120–124	—	—	—	—	—	1	—	—	1	—	1	—	2	1
115–119	—	—	—	—	—	1	1	—	—	—	—	—	1	1
110–114	—	—	2	1	—	—	1	—	1	—	—	—	4	1
105–109	—	—	—	—	1	—	2	—	—	1	—	—	3	1
100–104	—	—	—	—	1	—	2	1	2	—	—	—	5	1
95–99	1	—	2	—	5	—	5	1	4	1	—	1	17	3
90–94	—	—	1	—	4	—	4	3	5	3	—	—	14	6
85–89	—	—	1	1	10	1	8	—	3	4	2	—	24	6
80–84	—	—	1	1	8	2	6	1	7	2	1	1	23	7
75–79	—	—	1	2	5	4	7	2	4	3	—	—	17	11
70–74	—	—	—	—	4	4	7	2	4	4	1	—	16	10
65–69	—	—	4	1	3	2	4	1	2	—	—	—	13	4
60–64	—	—	2	—	3	2	—	—	1	2	1	—	7	4
55–59	—	—	—	—	1	2	—	—	—	—	—	—	1	2
TOTALS	1	—	14	6	45	19	47	11	34	20	6	2	147	58

* Tested on Revised Stanford-Binet Intelligence Scale, Terman/Merrill Form L.

(II)

Action recommended by Medical Officer	Boys	Girls	Total	
(a) No Action	37	15	52	25.3%
(b) Referred to Educational Psychologist	9	3	12*	5.8%
(c) Referred for consideration for remedial teaching	26	3	29	14.2%
(d) Referred to, or already attending, Child Psychiatric Clinic	7	—	7	3.4%
(e) To be retested before decision taken	1	—	1	.49%
(f) RECOMMENDED FOR SPECIAL EDUCATIONAL TREATMENT	69	38	107*	52.2%

* Three children are included in both tables.

It will be noted that 107, or 52.2% of the total examined, were considered to require special educational treatment, this number being found in an estimated school population of 3,580 children aged between eight and eleven (2.9%). Thirteen of this number were recommended for attendance at special schools, and 11 have been admitted (8 to the Lady Adrian School and 3 to residential schools). It was considered that the needs of the remaining 94 would be met by attendance at special classes attached to ordinary schools.

It is not considered from the way in which this survey was planned that all the children in need of special educational treatment were discovered, and the percentage is lower than that which would normally be expected. At a later date it will be interesting to carry out a more detailed survey, statistically planned, so that the results would be generally applicable to schools in the Authority's area.

I should like to take this opportunity of recording my thanks to the teachers for their help and co-operation.

It is considered that the survey has shown that there is a need for the provision of special classes attached to primary schools in the rural area, and it is hoped it may eventually be possible for classes to be set up in the villages where there is a village college, so that the college transport can also be used for children attending the special classes. The present shortage of teachers, and in particular those specially trained in the teaching of backward children, make the solution of the problem particularly difficult.

(2) **Special Educational Treatment—All Handicaps.**

The following table relates to children attending special schools, or on the waiting list for admission to special schools.

		1. Blind 2. Partially Blind		3. Deaf 4. Partially Deaf		5. Delicate 6. Physically Handicapped		7. Educationally sub-normal 8. Maladjusted		Epileptic	Totals
		1	2	3	4	5	6	7	8	9	1-9
On waiting list, December 1959	*	—	—	—	—	—	2	7	—	—	9
	†	—	—	—	—	1	—	10	—	—	11
Added to waiting list during 1960	*	—	—	2	—	—	5	23	1	—	31
	†	1	1	—	—	4	1	9	2	—	18
Admitted to Special Schools during 1960	*	—	—	2	—	—	7	19	—	—	28
	†	1	1	—	—	3	1	12	1	—	19
Discharged from Special Schools during 1960	*	—	—	—	—	—	—	1	1	—	2
	†	2	—	2	—	1	1	10	3	—	19
In Special Schools at end of 1960	*	—	—	2	—	—	22	31	—	—	55
	†	4	4	4	1	5	4	36	2	—	60
On waiting list, December 1960	*	—	—	—	—	—	—	10	1	—	11
	†	—	—	—	—	1	—	7	1	—	9

* Day. † Boarding.

(3) Handicapped Young Persons

It is not always easy to find employment for handicapped school leavers, and in this connection I am glad to be able to reproduce, with the permission of the Chief Education Officer, the comments of the County Youth Employment Officer in her Annual Report to the Youth Employment Sub-Committee on this subject.

" Sometimes normal school-leavers find the transition from school to work difficult, but for the handicapped child this is particularly true. It is therefore most important that these boys and girls should whenever possible be placed, as soon as possible after leaving school, in work which is within their capacity. The guidance and placing of these children is worthwhile and rewarding, but it is time-consuming, especially as so many employers nowadays (owing to the increased numbers of school-leavers becoming available for work) seem reluctant to give a handicapped youngster a trial. Many of them are emotionally unstable and immature in their outlook on life, but given sympathetic handling they often become loyal, reliable workers in the type of routine repetitive work which normal young folk may find boring and frustrating and give up after a short time. The main difficulty in finding suitable places in industry for many of the handicapped boys and girls seems to be the problem of " pace ". If some arrangements could be made for these young folk to attend an Adjustment to Industry Course (devised to suit their particular needs) either before, or immediately after, leaving school this difficulty of pace-adjustment might largely be remedied.

Few handicapped school leavers apply for registration under the Disabled Persons (Employment) Act, and unless the handicap is very severe this attitude is encouraged. Where parents have some knowledge of the provisions of the Act, they seem frequently to have set their minds on some Vocational Training for their children, and become very discouraged indeed when this does not become available.

Twenty-eight handicapped boys and girls left school during the year. Eight applied for admission to the Disabled Persons' Register, but one withdrew her application because she was unfit for work. Two others were ineligible for registration because they have so far proved to be unemployable."

(3) Section 57 of the Education Act, 1944

Cases reported to the Local Health Authority under Section 57(3) as being incapable of receiving education at school (prior to the coming into force of the Mental Health Act, 1959, on 1.11.60)	2
Cases reported to the Local Health Authority under Section 57(5) as requiring supervision after leaving school (prior to the coming into force of the Mental Health Act, 1959, on 1.11.60)	16
Cases reported to the Local Health Authority under Section 57(4) as being unsuitable for education at school (since 1.11.60)	Nil

With the coming into operation of the Mental Health Act, 1959, on the 1st November, 1960, the Ministry of Education issued Circular 12/60 which had the effect of changing the old procedures of Section 57 of the Education Act, 1944, into a form more consistent with the spirit of the new Mental Health legislation. Thus, for example, it is no longer necessary, where the parents are willing, for ponderous formalities to take place over the admission of a subnormal child to the Local Health Authority's training schemes instead of following the normal education pattern.

CHILD PSYCHIATRIC SERVICE

A. The following cases were referred to the Child Psychiatric Clinic by the School Health Service staff.

Type of case	Boys	Girls	Total
Behaviour disorders	11	2	13
Habit disorders	7	4	11
Nervous disorders	3	4	7
Educational failure	11	6	17
Totals	32	16	48

In July the Authority's Educational Psychologist resigned, and no replacement was able to be found by the end of the year. The Child Psychiatric Service has continued to grow in its activities, and we find that we are making increasing demands upon its services. A fuller report on this service will be found in my Annual Report as County Medical Officer for 1960.

B. I am indebted to Dr. R. E. Glennie, Consultant Child Psychiatrist, for the following tables:

CAMBRIDGE COUNTY CHILDREN

New cases referred and examined in 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	24	24	School Medical Officer's Dept.	2	2
GPs and Consultants	14	8	GPs and Consultants	22	15
Juvenile Court Magistrates	2	—	Juvenile Court Magistrates	—	—
Others	3	1	Others	1	—
	43	33		25	17
Number of new cases taken on for treatment:		30	Number of new cases taken on for treatment:		15

Total number of new cases examined: 68
Number of new cases taken on for treatment: 45

Cases under observation and treatment 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	21	21	School Medical Officer's Dept.	2	2
GPs and Consultants	11	9	GPs and Consultants	10	7
Others	5	5			
	37	35		12	9

Number of old cases under observation and treatment: 49
Total number of cases from the County of Cambridge under observation and treatment (including those seen for the first time in 1960): 102

CAMBRIDGE CITY CHILDREN

New cases referred and examined in 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	20	20	School Medical Officer's Dept.	2	2
GPs and Consultants	33	19	GPs and Consultants	15	6
Juvenile Court Magistrates	12	3	Others	—	—
Others	15	11			
	80	53		17	8
Number of new cases taken on for treatment:		41	Number of new cases taken on for treatment:		12

Total number of new cases examined: 97
Number of new cases taken on for treatment: 53

Cases under observation and treatment 1960

Chesterton Child Psychiatric Clinic			Addenbrooke's Hospital		
Source of cases	Number examined	Notified to S.M.O.	Source of cases	Number examined	Notified to S.M.O.
School Medical Officer's Dept.	11	11	School Medical Officer's Dept.	3	3
GPs and Consultants	21	16	GPs and Consultants	18	7
Juvenile Court Magistrates	8	5			
Others	6	3			
	46	35		21	10

Number of old cases under observation and treatment: 67
Total number of cases from the City of Cambridge under observation and treatment (including those seen for the first time in 1960): 120

EDUCATIONAL PSYCHOLOGIST

A. Number of cases referred to Educational Psychologist by School Health Service Staff:

Boys	Girls	Total
12	3	15

B. Number of cases referred by School Health Service staff for assessment as to suitability for Remedial Reading Teacher:

Boys	Girls	Total
20	3	23

The Educational Psychologist, Mrs. V. M. W. Lyall, left the Council's service on August 31st, and no appointment of a successor had been made by the end of the year. I am indebted to the Chief Education Officer for making available Mrs. Lyall's final report.

Report of the Educational Psychologist
for the period 1st September, 1959, to 31st August, 1960

" During the year, new referrals from all sources, added to the backlog of cases, made a total of 303 cases awaiting attention. Of these, 250 were dealt with, leaving 53 cases outstanding. Separate figures for the city and the county are as follows.

	City	*County*	*Total*
Cases referred	55	248	303
Cases dealt with	53	197	250
Cases remaining	2	51	53

The term " dealt with " covers action on the part of the Educational Psychologist ranging from the giving of weekly individual treatment to the compilation of a waiting list of children suitable for remedial teaching in reading. In the county the best possible use has been made of the service. Direct referrals by Head Teachers made up the largest single group of cases dealt with, and the many cases referred by the School Medical Department were accompanied by full relevant details which were most helpful to the Psychologist. The close co-operation of the School Medical Department has been very much appreciated. In the city those contacts that have been made direct with Head Teachers have been extremely satisfactory, though referrals continue in the main to come through the City School Medical Officers, and to be limited to requests for assessment of intelligence.

A rather disturbing feature of the work is the backlog of cases which, even when work is limited to diagnosis and the minimum of advice and help, persists. Although this is an indication of wide interest in the service, there is the danger that unless this interest is satisfied by the provision of adequate and prompt treatment for the cases brought forward, the enthusiasm and response of Head Teachers, at present very good, may be lost. The aspects of work which a complete school psychological service should cover are diagnosis, individual weekly treatment sessions, advice to schools, advice and support to parents, lectures and courses for teachers and parents, the carrying out of surveys, full reports on all cases, recording and filing, and the maintenance of contact through professional organisations with up-to-date developments and trends in testing and psychological techniques generally.

Remedial Reading

Miss D. Birchall, who was appointed to teach small groups of retarded readers in primary schools in the rural area, has just completed a year's work in the rural area, and an assessment of her contribution is of value at this point. The following table shows the extent of the demand for her help, and the extent to which it has been possible to satisfy this.

Number of children for whom remedial reading help has been sought:	201
Number of these rejected (as too old, too dull, etc.)	23
Number given help so far	53
Number of these to continue next term	16
Number selected for inclusion beginning next term	36
Number of schools requesting remedial reading help for one or more pupils	45
Number of schools given help	12
Number of these to continue next term	6
Number of schools to receive help beginning next term	6

From these figures it appears that one remedial teacher working in the scattered rural area can satisfy about a quarter of the need for remedial reading help in Cambridgeshire. As the whole problem could not be dealt with, it was decided to give priority to children of at least average intelligence, and to include duller children only where there was room in a group already formed at their school. The duller children have not been excluded as unable to benefit from this individual approach which indeed, given in their early primary school years, often affords by far their best chance of achieving literacy, so that its value for them cannot be over-estimated. It was felt, however, that an intelligent child's failure to master reading had more serious implications, and constituted a more urgent problem, which, until it was possible to help all the children needing individual tuition in reading, must have priority.

The ultimate intention is that children needing it shall receive this remedial teaching during their first or second junior school years, before their difficulty has hardened into a real handicap, complicated by feelings of failure, inferiority and dislike of reading. At this early stage the length of time needed to bring a child's reading up to standard for its age could be expected to be comparatively short, and certainly not more than a year in nearly all cases. Even the most stubborn cases would have plenty of time to be resolved before leaving the primary school. Used in this way, remedial reading teaching of this kind can justifiably be limited to primary school children although during this initial year when it has been necessary to do what was possible for the reading failures in their last year at primary school, it has inevitably seemed premature in some cases to discontinue remedial reading sessions because a child was transferring to a secondary school.

Experience shows that from three to five children is the best size for a remedial reading group. This size of group provides sufficient stimulus of competition while allowing time for adequate individual help. In practice it has not always been possible to limit the groups to five, in schools where the reading retardation problem is very large, and of the 12 schools visited this year two have had groups of seven children. Of the other 10 schools, two had groups of five, four had groups of four, and four had groups of three children. Of these 52 children helped, 19 were aged 10 or more on admission. 14 were aged 9-10, 17 were aged 8-9 and two were under eight.

Progress has been most satisfactory in general. A gain of 12 months of reading age being taken as average progress over a school year, only nine of the 52 children helped failed to make at least average progress, while 13 children progressed at more than double the average speed. When it is remembered that until they were given remedial reading help these children had on an average progressed at just over a quarter of the normal pace, it will be seen that the overall advance made during one year of remedial help has been all that could be hoped for. There has been only one complete failure. A nine-year old boy failed to make any progress at all during six months in a group. He joined the group with a reading age of nil and a determined attitude of non-co-operation. At the end of the school year, still a complete non-reader, he was precluded from the group, as it was felt that the sort of disciplinary measures needed in his case were out of place in a small group of children, many of whom were already fearful and unconfident in their attitude to failure.

A session of three-quarters of an hour has been found satisfactory in general, though in the larger groups an hour has been given where possible. During the year experiment has shown that a single weekly session is unsatisfactory and that three visits a week, though ideal, limits too severely the number of schools that can be given help. Schools are therefore visited twice a week, and two schools, in an area where the retardation problem is severe, receive a third visit. The travelling involved has been about 300 miles a week, and half a day has been allowed for office work—ordering of books, measuring of progress, preparation and marking of work and tests, discussion of problems, and so on.

It has been found that the attitude of the Head Teacher towards receiving remedial help is strongly reflected in the progress made by the pupils in individual school groups. In the two schools where the best co-operation exists the whole group has in each case made outstanding progress, averaging a gain in reading age of two years three months, compared with the overall average gain in the whole group of one year six months. An indifferent or apathetic attitude has been found more damaging than a suspicious or critical one on the part of the Head Teacher.

This first year has been looked on to some extent as a trial period. At the end of it, it was decided to close some remedial groups. Where on the one hand the majority of the children were leaving or had reached a point at which they could be expected to hold their own in their normal classes, and there were no further cases of severe retardation awaiting help, the group was discontinued as no longer in need of help. On the other hand, certain schools were considered to have shown that they were unable to benefit sufficiently to justify continuance of help in face of the very considerable waiting list, and these groups were closed so that the limited help available could be used to the best advantage. This has meant that six of the existing groups will continue next year, and new groups will be started covering six schools for which it has not been possible to provide before.

After this year's trial period, it may be said that the appointment of the remedial reading teacher has been thoroughly justified and that results show this to be the right approach to a complete solution of the problem of reading retardation in the rural area. It is felt that a staff of four could make this problem, which was so acute in my predecessor's time, a thing of the past in Cambridgeshire.

The importance of close contact and co-operation between remedial teacher and Educational Psychologist has been clearly shown during the year. Initial assessment and selection of cases by the Psychologist has enabled the remedial teacher to use the most appropriate approach and method for each child from the beginning, while the Psychologist has been helped enormously by having available appropriate treatment for the many children whose school failure and even behaviour difficulties have arisen from an inability to read. Both psychologist and remedial teacher have found it important to maintain contact in respect of children receiving remedial help, and a weekly discussion of current problems has been most rewarding in insuring continued progress, in anticipating individual needs, and in the guiding of the development of each child according to his needs.

In concluding this report, the Educational Psychologist wishes to thank those who have helped to make her short term of employment in Cambridgeshire both interesting and pleasant. Family commitments which make full-time employment undesirable have made it necessary to resign, but this decision was reached reluctantly, and the loss involved in relinquishing this stimulating and challenging work in a friendly department has been a real one."

V. M. W. LYALL.

SPEECH THERAPY

For the first nine months of the year the establishment of three Speech Therapists for the City and rural area was filled. Miss Powell, however, left the Council's service on November 27th, and a full-time successor had not been appointed by the end of the year. Two part-time Speech Therapists, Mrs. Emerson and Mrs. Levett, were appointed for a total of five sessions per week to treat the urgent cases in those parts of the City and rural area not served by a full-time therapist.

At the end of the year the question of the appointment of a further Speech Therapist was under discussion, and it is hoped that the establishment will be increased in 1961 since there are at present more cases requiring treatment than the Speech Therapists can manage and treatment is often being given only once weekly when it should be given twice weekly.

The following tables relate to the work of the speech therapists during 1960.

A. **Cases**

	Rural Area		City		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
(i) Number referred for Speech Therapy	115	51	61	22	176	73
(ii) Number of (i) found to require treatment	101	43	53	19	154	62
(iii) Total number treated	153	56	114	62	267	118
(iv) Number discharged	50	13	37	21	87	34
(v) Number under treatment at end of 1960	103	43	80	41	183	84
(vi) Number on waiting list at end of 1960	90	43	49	9	139	52
(vii) Number not examined at end of 1960	7	5	2	1	9	6

B. **Speech Defects of children examined** (section A (ii) above).

	Rural Area		City		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
(i) Cleft Palate	1	1	—	—	1	1
(ii) Sigmatism	29	15	7	4	36	19
(iii) Other defects of articulation and language	51	21	32	8	83	29
(iv) Stammer	14	5	9	4	23	9
(v) Voice disorders	5	—	1	1	6	1
(vi) Other defects	1	1	4	2	5	3
Totals	101	43	53	19	154	62

C. **Cases closed during 1960** (Section A (iv) above).

1. After Treatment.

	Rural Area		City		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
(a) Speech Normal	21	4	13	5	34	9
(b) Speech Improved						
(i) Speech satisfactory	15	5	15	6	30	11
(ii) Left school or district	10	2	5	3	15	5
(iii) Unsuitable for further treatment	1	—	3	4	4	4
(iv) Parents refuse further treatment	2	—	—	2	2	2
(v) Referred elsewhere	—	2	1	—	1	2
(c) No Improvement						
(i) Left school or district	1	—	—	—	1	—
(ii) Unsuitable for further treatment	—	—	—	—	—	—
(iii) Parents refuse treatment	—	—	—	—	—	—
(iv) Referred elsewhere	—	—	—	1	—	1
Totals	50	13	37	21	87	34

2. Removed from waiting list.

	Rural Area		City		Total	
	Boys	Girls	Boys	Girls	Boys	Girls
(i) Left School or District	11	5	3	—	14	5
(ii) Spontaneous recovery after advice	4	—	1	2	5	2
(iii) Treatment refused	—	—	1	—	1	—
Totals	15	5	5	2	20	7

The Speech Therapists have submitted the following report on their work:

" Throughout the year treatment has been given at Auckland Road clinic, Romsey Health Centre, the Roger Ascham School, the Lady Adrian School, at various schools in the rural area and City and at a few homes where conditions have been suitable. In addition one of the therapists has visited the Training Centre for subnormal children for one session each month since March, to give advice to parents and teachers.

The position regarding accommodation for treatment at schools has shown some improvement during the year.

The second tape recorder which we acquired in April has proved a most valuable addition to our equipment. Continued discussions held at the Child Psychiatric Clinic are very much appreciated. Furthermore, it has been of great benefit to be able to refer doubtful cases of hearing loss for preliminary audiometric screening by the school nurse.

During the year visits have been made to the Deaf Unit at Sedley School and to Tixover Grange Residential School for Spastics.

The total number of children on the treatment register in 1960 was 385. In the spastic group there were nine boys and ten girls—a ratio of approximately 1:1. The rest were divided into 258 boys and 108 girls giving a ratio of approximately 2½:1. From this it will be seen that the ratio has remained constant since last year for general cases of speech defect, while the ratio for spastic children has changed.

During the year 43 children have achieved normal speech, and a further 41 were discharged with speech which is considered satisfactory, e.g. speech is normal except under conditions of great emotional stress, or there is a slight residual articulation defect which is barely noticeable and is not considered to be a handicap to the child. Eight children were discharged as being unlikely to benefit from further treatment.

In the case of physically handicapped children it must be remembered that it may not be possible to achieve completely normal speech, and treatment will be continued throughout most of their school life, but in general steady improvement is shown year by year.

We were sorry that Miss Powell left Cambridgeshire in November. Since then two part-time speech therapists have given a total of five sessions a week, one working in the City and one in the County area. However, even with our full complement of staff there are more children needing treatment than can be adequately handled, some of whom must remain on the waiting list for a very long time. The majority of children under treatment are seen weekly, but there are many children who would greatly benefit by receiving treatment twice weekly, if this were possible."

H. HRAMTSOV.
A. DUTT.

SCHOOL NURSING SERVICE

A. The County Nursing Officer has the following observations to make:

" It is encouraging to be able to report that many of the plans that were envisaged at the start of the year designed to give the School Health Service a new look and a more effective range have now been put into operation.

For some time it has been obvious that, with the changing pattern of health among children attending school, new measures were required to meet these changes.

The new scheme has only been in operation for some three or four months. After a guarded reception by the staff at the time of its debut it has now settled down and appears to be working well. It allows the Health Visitor/School Nurse to devote time previously taken up by routine medical examinations to visiting the schools, getting to know children, teachers and parents more thoroughly and to have a better knowledge of the problems pertaining to each.

The more regular appearance of the Health Visitor as adviser both in their schools and their homes will, it is felt, help to produce in the minds of the children concerned, a definite awareness of health.

During the year a second S.R.N. was appointed to work part-time, was trained in the use of the pure-tone audiometer and employed primarily on the ascertainment of deafness in schoolchildren. The remainder of this nurse's time is devoted to meeting needs elsewhere, both in schools and in the home.

The attendance of the Health Visitor at the B.C.G. sessions in the schools has provided her with a new field of interest and further opportunities for health education."

S. MEE.

B. The following figures relate to the work of nurses in connection with the School Health Service.

(i) Visits to Schools	
(a) Sessions of medical inspection attended	450
(b) Number of children prepared for medical inspection	9,292
(c) For hygiene inspections	315
(d) Other purposes	618
(ii) Visits to Homes of Scholars	
(a) Follow-up to secure treatment	3,404
(b) Special enquiries into infectious or contagious disease	128
(c) Other purposes	195

C. Verminous Inspections

School Groups	No. of children examined			No. of *Individual* children found to be infested			No. of visits to Schools by School Nurses
	by School Nurses	by School Medical Officers	Total	At School Nurse Exam.	At S.M.O. Examination	Total	
Village Colleges & Secondary Modern Schools	9427	1086	10513	2	—	2	27
Primary & Full Range Schools	20665	3052	23717	19	—	19	288
Totals	30092	4138	34230	21	—	21	315

Thirty eight cases of head infestation were reported in 1959, and 41 in 1958. The figure of 21 in 1960 therefore represents a considerable improvement.

INFECTIOUS DISEASES

Notifiable infectious diseases for the past six years, children aged 5-14.

	1955	1956	1957	1958	1959	1960
Diphtheria	—	—	—	—	—	—
Dysentery	5	16	6	43	18	55
Encephalitis, Acute	1	1	1	—	—	—
Erysipelas	—	1	—	—	1	—
Food Poisoning	2	1	8	10	2	2
Measles	741	364	462	374	1,715	104
Meningococcal infection	—	—	1	—	—	—
Paratyphoid	—	—	1	—	—	—
Pneumonia	2	2	6	3	2	2
Poliomyelitis, paralytic	1	6	4	—	—	—
Non-paralytic	1	2	—	—	—	—
Scarlet Fever	51	44	30	87	139	75
Tuberculosis, Pulmonary	1	1	6	1	4	2
Non-Pulmonary	2	4	1	2	—	—
Whooping cough	133	93	210	13	80	53

Non-notifiable infectious diseases reported by Head Teachers, last six years.

	1955	1956	1957	1958	1959	1960
German measles	9	15	18	44	32	5
Mumps	279	73	295	342	237	180
Chickenpox	296	203	190	150	602	154

VACCINATION AND IMMUNISATION

A. Immunisation against diphtheria, whooping cough and tetanus

The following table shows the number of children aged 5-14 in the rural area immunised during 1960 against diphtheria, pertussis and tetanus.

DIPHTHERIA ONLY		PERTUSSIS ONLY		TETANUS ONLY	
Primary	Booster	Primary	Booster	Primary	Booster
1	339	14	2	266	87

DIPHTHERIA AND TETANUS		DIPHTHERIA AND PERTUSSIS		TRIPLE ANTIGEN	
Primary	Booster	Primary	Booster	Primary	Booster
19	43	9	51	49	479

B. Vaccination against Poliomyelitis

The figures relating to vaccination against poliomyelitis have been kept in the form required for Ministry of Health returns, and it is not possible to give the number of schoolchildren vaccinated. It is known, however, that 2,542 children born in the years 1943 to 1960 received the second injection. The third injections are shown in the Ministry returns as a total figure not broken down into age groups, but there is no reason to suppose that children who have received two injections have not at the appropriate time received the third injection.

PROVISION OF MILK AND MEALS, 1960

The arrangements for the supply of milk in schools have continued as before, and in September 1960 there were 9,396 children receiving it, or 81.52% of the total in attendance. Of those in attendance at the Nursery School 90.00 per cent received it, at Primary Schools 92.8 per cent and at Secondary Schools 62.45 per cent.

The following are the figures relating to the designation of the milk supplied to the schools:

Tuberculin Tested	9
Pasteurised	99
Tuberculin Tested Pasteurised	4
	112

Cooked mid-day meals were available for all schools, and a total of 7,424 children or 65.72 per cent received them. At the Nursery School 93.33 per cent took the meals, at Primary Schools 57.58 per cent and at Secondary Schools 80.03 per cent.

The number of children receiving free meals on a scale of means approved by the Education Committee was 395.

PHYSICAL EDUCATION

I am particularly grateful for the following report of the Organisers of Physical Education. Physical education is an integral part of the programme for the promotion of the health of the school child.

" PRIMARY

The work in the Primary Schools is influenced not only by the weather and local facilities, but by the courses and developments which take place during the year.

Courses for training of Primary Teachers 1960

(1) **A Course for Infant Teachers**

This course was run on experimental lines, after discussion with the Headmistresses of Infant Schools in Cambridge. It was decided to ask four schools to show children working with their own teachers, to County and City teachers. One evening a week for four weeks the teachers saw two classes working. It was of great interest to everyone to see the different approach to basic work with the various types of apparatus on which the work is based. An extra session of discussion was asked for by the teachers. An average of 80 teachers attended each session.

(2) **Four Remedial Lectures and Demonstrations run in conjunction with the Principal School Medical Officer**

During 1959 the Principal School Medical Officer discussed with the Organisers the need to emphasise remedial exercises as there had been an increase in the numbers of children with flat feet in the County and he also felt that more attention could be paid to poor posture and shallow breathing. Four sessions were arranged at Village Colleges to which primary and secondary teachers in the area were invited. At each session one of the School Medical Officers spoke on posture and foot deformities, and exercises were demonstrated by the Organiser, and discussion followed. It was agreed that the exercises demonstrated at these sessions would be printed in leaflet form and given to the teachers and parents, so that the children who have postural deformities can be helped at school and at home.

It is pleasing to record the practical interest taken in Physical Education by the County Medical Officer and his Deputy, not only through Teachers' Courses but also in visits to Primary and Secondary Schools with the Organisers to see the normal Physical Education lesson in progress. Dr. Tyser agreed to address the Cambridge and District Physical Education Club at one of their meetings and Dr. Drummond will speak to the specialist teachers in Physical Education (Men) at their course in February of 1961. One of your Organisers accompanied them on a visit to Marlborough School to see their school programme of remedial gymnastics and weight training which has received considerable publicity in recent years.

During the Autumn Term there is usually an emphasis on work using small apparatus and much of the skill training is done together with dancing which varies in type from school to school. The Physical Education programme in some schools is, however, still restricted owing to the lack of accommodation in winter months. During the Spring and Summer terms the daily lesson is taken outside whenever possible and the syllabus includes a much wider variety of activity including the use of larger climbing apparatus, games training, dance and swimming. Throughout the year there was an emphasis on exercises with a remedial bias.

In the schools in Cambridge from which teachers attended the Infant Course there has been a wave of new ideas and more variety in the use of apparatus. Many schools are now asking for more large apparatus to allow the children to explore, invent, climb, balance, swing and jump in new ways.

Throughout the County, physical education continues to be alive and lessons are, as a general rule, becoming more comprehensive. The stereotyped and formal lessons are only seen very occasionally.

The normal pattern of physical education in the primary schools is as follows:

Spring Term

1. The daily physical education lesson outside whenever possible.
2. Indoor lessons in bad weather with remedial bias.
3. Dance training possibly for a Festival.
4. Movement with music (infants).
5. Games training and some fixtures with other schools.

Summer Term

1. The daily physical education lesson including sports practices.
2. Swimming lessons.
3. Plenty of opportunity to work on large apparatus in playground.
4. May Day Festivals of Dance—usually out of doors.
5. Area Sports Meetings.
6. Cricket and rounders fixtures.

Autumn Term

There is usually an emphasis on the work using smaller apparatus. Much of the training in skills is done this term. A remedial bias to the lesson is encouraged. Some dance and games training and in some schools football and netball fixtures are included in the Physical Education programme.

SECONDARY

Secondary work in the county depends so much on the team of specialist teachers and the influence they have on the children all working to make maximum use of facilities available. Unfortunately, there is still a national shortage of Physical Education teachers and throughout the year there have been many changes of staff, and some schools were without a full-time specialist teacher. With the building of more new gymnasia and the very adequate playing fields, the work should become more comprehensive. Training courses for teachers and regular visits to schools are essential.

The following courses were arranged for secondary teachers:—

(1) **A Course for Physical Education Teachers in Secondary Schools**
This course was held at Netherhall Girls' School, Cambridge, and teachers from the County and City were invited to attend. Demonstration lessons were taken with different age groups of children from Netherhall School by the Organiser; two classes were taken on one evening a week for five weeks. A class of senior girls from Burwell Secondary Modern School showed their work on the last evening of the course. Teachers were encouraged to help practically and discuss afterwards the content of the lesson. It was disappointing that not all teachers from the County Secondary Schools attended the course, but as these teachers were leaving the County in July, perhaps it was not surprising.

(2) **A Course for Lawn Tennis Coaches**
This course was held at Fenners on the weekend 2nd and 3rd April. The Committee's Organiser and the Secretary of the coaching section of the Cambridgeshire Lawn Tennis Association arranged the course together and teachers and members nominated from local clubs attended. Mr. H. L. Smith, the University Coach, took the coaching sessions and these were followed by the latest Dan Maskell coaching films and discussions.

(3) **A Swimming Course**
A one-day swimming course with the accent on " Teaching Learners " was held at the Leys School indoor bath in December and was attended by over 60 teachers from the County and the City. The excellent lectures and demonstrations given by Mr. Kinnear, the National Coach to the Amateur Swimming Association, should do much to help teachers and encourage them to try the more up-to-date techniques in swimming instruction.

(4) Secondary teachers were encouraged to attend the Remedial sessions mentioned previously.

A full programme of fixtures in all major games has been carried out and every effort made to encourage children to pursue these interests as adult members of teams after leaving school.

Swimming

Greater emphasis continues to be placed on the need for swimming instruction as part of the Physical Education programme and maximum use has been made of the limited times available to schools at the Cambridge, Royston, Newmarket and Saffron Walden baths. Both primary and secondary schools continue to build their own pools and as it is now recognised that swimming is taught as a means of survival as well as for enjoyment, these pools will help greatly to reach the aim of teaching every child to swim before leaving school.

Secondary Games

Perhaps the most significant advance during the year has been the developments in the co-ordination of secondary sport in the County and to establish it under one Association now called " The Cambridgeshire Secondary Schools Sports Association ". Two bodies have operated in the past, the older Cambridgeshire Sports Association which began in the days of the all-age school, and the newer Francis Trophy Committee which catered only for sport in the Village Colleges. Unfortunately this led to some duplication of fixtures between schools and also inter-school competitions, the latter particularly requiring considerable organisation to be run successfully but once a year. However, these two bodies have now agreed to merge and competitive sport will now be organised in all major games by the newly-named Association, at Inter-school, County and National level. The Francis Trophy itself will be retained and awarded to the school with the best over-all record in games.

New Gymnasia

With the opening of new village colleges the facilities for secondary physical education are all the time improving and there should be ample opportunity for good work and developing and widening the curriculum. It is hoped that we can encourage teachers of quality to come and make full use of our excellent facilities. The Sports Hall at Sawston is a most exciting experiment. It is certainly in keeping with modern developments of Physical Education in that it allows scope for numerous activities and is not limited only to gymnastics. A group of Organisers from the Eastern Area came to see this new venture and were very impressed."

U. M. J. TROTT.
J. G. MILNE.

Swimming pools were in use during 1960 at Gamlingay and Girton Schools, and work was started on a pool at Waterbeach School. Plans for two more pools, at Swavesey Village College and Stapleford School, were drawn up during the year.

I have made mention in the introduction to this Report of the value of the courses arranged by the Outward Bound Trust. During 1960 ten schoolchildren and two young persons attended these courses.

MEDICAL EXAMINATION OF TECHNICAL COLLEGE PUPILS

Medical examination of entrants to the Technical College was, as usual, carried out at the Shire Hall during the summer holidays, and the following is a summary of the results:

	Boys	*Girls*	*Total*
Number of pupils examined	75	97	172
Defects discovered:			
Defective vision			
For observation	5	9	14
For treatment	5	3	8
Nose and Throat defects			
For observation	5	5	10
For treatment	—	1	1
Hearing	—	1	1
Orthopaedic	6	16	22
Circulatory	1	—	1
Skin	5	5	10
Other conditions	9	11	20

No cases of unsatisfactory physical condition were noted.

MEDICAL EXAMINATION OF TEACHERS AND ENTRANTS TO TEACHERS TRAINING COLLEGES

As in previous years, members of the Health Department have carried out medical examinations of entrants to the teaching profession and applicants for admission to training colleges. In addition they are now responsible for the medical examination of all persons appointed to the Council's staff. The following figures relate to the medical examination of teaching staff by the School Medical Officers in 1960.

(i) Entrants to teachers training colleges	22
(ii) Appointed to the Council's staff	
(a) Entrants to the teaching profession	12
(b) Other teaching staff	16
	50

DEATHS OF SCHOOL CHILDREN

Boys

Age	Causes of Death
7	Suffocated by drowning whilst bathing in river.
9	Cerebral contusion and fractured skull—knocked over by motor vehicle.
12	Bronchopneumonia and lymphosarcomatosis.
13	(1) Staphylococcal pyaemia, (2) carbuncle on back.

Girls

Age	Causes of Death
5	Acute lymphatic leukaemia
11	Gun shot wounds.

There were six deaths of schoolchildren in 1960, compared with 9 in 1959, but of these two were caused by accidents and one by violence. The number of accidental deaths is in accordance with the national average where about one third of the deaths of schoolchildren are due to accidents.

The death caused by staphylococcal pyaemia is of some medical interest as the causative organism, the staphylococcus, is a common inhabitant of the skin and is present in boils, carbuncles and septic spots. It has acquired resistance to many of the modern antibiotic and chemotherapeutic drugs and so has become, particularly in hospital practice, an extremely difficult organism to deal with and control.

The reduction of the number of schoolchildren who died as a result of motor accidents from three in 1959 to one in 1960 has unfortunately not been parallelled by a similar drop in the number injured, as the following table shows.

Motor Accidents to Schoolchildren in the County of Cambridge.

	1959	1960
Killed	3	1
Serious Injuries	9	16
Slight Injuries	24	43
TOTALS	36	60

It must be pointed out that a considerable number of the children injured were non-resident and were in fact travelling through the County by car when involved in accidents.

APPENDIX I

RURAL AREA

Number of pupils on registers of maintained primary and secondary schools (including nursery and special schools) in January, 1961 12,015

PART I.—MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS).

TABLE A.—PERIODIC MEDICAL INSPECTIONS.

Age Groups Inspected (By year of birth) (1)	No. of pupils inspected (2)	Physical Condition of Pupils Inspected			
		SATISFACTORY		UNSATISFACTORY	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
1956 and later	70	70	100.00	—	—
1955	868	863	99.42	5	.58
1954	363	354	97.52	9	2.48
1953	301	299	99.34	2	.66
1952	733	726	99.05	7	.95
1951	242	239	98.76	3	1.24
1950	58	57	98.28	1	1.72
1949	84	81	96.43	3	3.57
1948	82	82	100.00	—	—
1947	88	87	98.86	1	1.14
1946	872	872	100.00	—	—
1945 and earlier	377	375	99.47	2	.53
TOTAL	4138	4105	99.20	33	.80

TABLE B.—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS.

(excluding dental diseases and infestation with vermin)

Age Groups inspected (by year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total Individual Pupils (4)
1956 and later	3	14	10
1955	19	184	174
1954	19	89	90
1953	10	90	79
1952	46	187	201
1951	20	87	60
1950	5	17	19
1949	6	22	21
1948	8	18	19
1947	7	13	15
1946	53	119	145
1945 and earlier	24	40	57
TOTAL	220	880	890

TABLE C.—OTHER INSPECTIONS.

NOTES:—A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher or other person.
A re-inspection is an inspection arising out of one of the periodic medical inspections or out of a special inspection.

Number of special inspections	682
Number of re-inspections	4310
Total	4992

TABLE D.—INFESTATION WITH VERMIN.

(a)	Total number of individual examinations of pupils in schools by school nurses or other authorised persons ..	34,230
(b)	Total number of individual pupils found to be infested ..	21
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	Nil
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	Nil

PART II. DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR.

TABLE A.—PERIODIC INSPECTIONS.

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
(1)	(2)	Requiring treatment (3)	For observation (4)	Requiring treatment (5)	For observation (6)	Requiring treatment (7)	For observation (8)	Requiring treatment (9)	For observation (10)
4	Skin	28	45	28	14	24	23	80	82
5	Eyes—								
	a. Vision	45	122	81	106	94	93	220	321
	b. Squint	17	22	1	2	8	11	26	35
	c. Other	7	13	4	6	14	11	25	30
6	Ears—								
	a. Hearing	19	24	10	7	19	29	48	60
	b. Otitis Media	3	25	4	2	6	23	13	50
	c. Other	5	6	1	1	4	6	10	13
7	Nose and Throat	21	133	13	16	24	91	58	240
8	Speech	32	30	4	11	35	17	71	58
9	Lymphatic Glands	2	112	1	7	9	72	12	191
10	Heart	1	27	1	13	8	15	10	55
11	Lungs	11	28	4	9	13	13	28	50
12	Developmental—								
	a. Hernia	—	7	1	1	3	4	4	12
	b. Other	5	28	3	4	7	25	15	57
13	Orthopaedic—								
	a. Posture	7	13	18	17	15	18	40	48
	b. Feet	41	37	9	15	52	34	102	86
	c. Other	26	29	41	36	17	18	84	83
14	Nervous System—								
	a. Epilepsy	1	3	1	2	1	—	3	5
	b. Other	5	14	1	7	9	11	15	32
15	Psychological—								
	a. Development	9	22	2	19	18	34	29	75
	b. Stability	14	44	2	27	18	41	34	112
16	Abdomen	5	8	1	5	7	16	13	29
17	Other	49	33	40	37	71	33	160	103

TABLE B.—SPECIAL INSPECTIONS.

Defect Code No.	Defect or Disease	Special Inspections	
		Requiring Treatment	For Observation
4	Skin	4	1
5	Eyes—		
	a. Vision	28	18
	b. Squint	—	—
	c. Other	3	3
6	Ears—		
	a. Hearing	2	6
	b. Otitis media	1	1
	c. Other	—	1
7	Nose and Throat	2	4
8	Speech	10	5
9	Lymphatic Glands	1	1
10	Heart	—	—
11	Lungs	1	1
12	Developmental—		
	a. Hernia	—	—
	b. Other	—	1
13	Orthopaedic—		
	a. Posture	—	1
	b. Feet	2	2
	c. Other	4	7
14	Nervous system—		
	a. Epilepsy	1	1
	b. Other	—	3
15	Psychological—		
	a. Development	7	23
	b. Stability	2	11
16	Abdomen	—	1
17	Other	16	5

PART III. TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS).

TABLE A.—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	10
Errors of refraction (including squint)	921
Total	931
Number of pupils for whom spectacles were prescribed	619

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	13
(b) for adenoids and chronic tonsillitis	182
(c) for other nose and throat conditions	16
Received other forms of treatment	52
Total	263
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1960	3
(b) in previous years	12

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS.

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	39
(b) Pupils treated at school for postural defects	9
Total	48

TABLE D.—DISEASES OF THE SKIN (excluding uncleanliness, for which see Table D of Part I).

	Number of cases known to have been treated
Ringworm— (a) Scalp	—
(b) Body	7
Scabies	2
Impetigo	25
Other skin diseases	45
Total	79

TABLE E.—CHILD GUIDANCE TREATMENT.

Pupils investigated or treated at Child Guidance Clinics	94

TABLE F.—SPEECH THERAPY.

Pupils treated by speech therapists	209

TABLE G.—OTHER TREATMENT GIVEN.

	Number of cases known to have been dealt with
(a) Pupils with minor ailments	144
(b) Pupils who received convalescent treatment under School Health Service arrangements	1
(c) Pupils who received B.C.G. vaccination	1,102
(d) Other than (a), (b) and (c) above— Please specify:	—
Total (a)-(d)	1,247

PART IV. DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY.

(1) Number of pupils inspected by the Authority's Dental Officers:—	
(a) At Periodic Inspections	1,042
(b) As Specials	587
Total (1)	1629
(2) Number found to require treatment	1305
(3) Number offered treatment	1203
(4) Number actually treated	764
(5) Number of attendances made by pupils for treatment, including those recorded at 11(h)	1285
(6) Half days devoted to:	
(a) Periodic (School) Inspection	9
(b) Treatment	209
Total (6)	218
(7) Fillings:	
(a) Permanent Teeth	762
(b) Temporary Teeth	21
Total (7)	783
(8) Number of Teeth filled:	
(a) Permanent Teeth	733
(b) Temporary Teeth	21
Total (8)	754

(9) Extractions:	
(a) Permanent Teeth	277
(b) Temporary Teeth	309
Total (9)	586
(10) Administration of general anaesthetics for extraction	12
(11) Orthodontics:	
(a) Cases commenced during the year ..	16
(b) Cases brought forward from previous year	57
(c) Cases completed during the year	15
(d) Cases discontinued during the year ..	10
(e) Pupils treated by means of appliances ..	11
(f) Removable appliances fitted	60
(g) Fixed appliances fitted	1
(h) Total attendances	252
(12) Number of pupils supplied with artificial teeth ..	16
(13) Other operations:	
(a) Permanent Teeth	109
(b) Temporary Teeth	45
Total (13)	154

APPENDIX II

CITY OF CAMBRIDGE

Number of pupils on registers of maintained primary and secondary schools (including nursery and special schools) in January, 1961	13,287

PART I. MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS).

TABLE A.—PERIODIC MEDICAL INSPECTIONS.

Age Groups Inspected (By year of birth) (1)	No. of Pupils Inspected (2)	Physical Condition of Pupils Inspected			
		SATISFACTORY		UNSATISFACTORY	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)
1956 and later	1306	1276	97.7	30	2.3
1955	133	129	97.0	4	3.0
1954	520	510	98.1	10	1.9
1953	520	514	98.8	6	1.2
1952	37	36	97.3	1	2.7
1951	703	693	98.6	10	1.4
1950	376	373	99.2	3	0.8
1949	23	23	100.0	—	—
1948	1058	1051	99.3	7	0.7
1947	45	45	100.0	—	—
1946	5	5	100.0	—	—
1945 and earlier	50	50	100.0	—	—
TOTAL	4776	4705	98.5	71	1.5

TABLE B.—PUPILS FOUND TO REQUIRE TREATMENT AT PERIODIC MEDICAL INSPECTIONS (excluding Dental Diseases and Infestation with Vermin).

Age Groups Inspected (By year of birth) (1)	For defective vision (excluding squint) (2)	For any of the other conditions recorded in Part II (3)	Total individual pupils (4)
1956 and later	3	182	155
1955	2	15	14
1954	21	74	88
1953	28	48	70
1952	5	2	6
1951	30	55	81
1950	22	33	51
1949	1	5	6
1948	62	108	156
1947	1	3	4
1946	—	2	2
1945 and earlier	1	3	3
TOTAL	176	530	636

TABLE C.—OTHER INSPECTIONS.

NOTES:—A special inspection is one that is carried out at the special request of a parent, doctor, nurse, teacher or other person.

A re-inspection is an inspection arising out of one of the periodic medical inspections or out of a special inspection.

Number of Special Inspections	342
Number of Re-inspections	1359
Total	1701

TABLE D.—INFESTATION WITH VERMIN.

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons ..	25,076
(b) Total number of individual pupils found to be infested ..	48
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	14
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

PART II. DEFECTS FOUND BY MEDICAL INSPECTION DURING THE YEAR.

TABLE A.—PERIODIC INSPECTIONS.

Defect Code No.	Defect or Disease	Periodic Inspections							
		Entrants		Leavers		Others		Total	
(1)	(2)	Requiring treatment (3)	For observation (4)	Requiring treatment (5)	For observation (6)	Requiring treatment (7)	For observation (8)	Requiring treatment (9)	For observation (10)
4	Skin	5	36	52	24	29	45	86	105
5	Eyes—								
	a. Vision	7	17	64	25	105	99	176	141
	b. Squint	22	29	—	1	10	16	32	46
	c. Other	8	10	12	6	23	20	43	36
6	Ears—								
	a. Hearing	5	26	—	6	3	10	8	42
	b. Otitis Media	6	28	—	7	—	12	6	47
	c. Other	2	2	1	—	2	7	5	9
7	Nose and Throat	38	204	10	12	29	103	77	319
8	Speech	12	26	1	5	8	23	21	54
9	Lymphatic Glands	—	58	—	1	—	15	—	74
10	Heart	6	1	4	11	4	9	14	21
11	Lungs	7	57	—	6	6	35	13	98
12	Developmental								
	a. Hernia	2	3	—	1	2	—	4	4
	b. Other	—	24	—	1	1	36	1	61
13	Orthopaedic—								
	a. Posture	10	2	14	13	28	36	52	51
	b. Feet	21	31	7	11	39	37	67	79
	c. Other	8	23	6	34	16	57	30	114
14	Nervous System—								
	a. Epilepsy	—	3	—	2	—	1	—	6
	b. Other	1	5	1	5	2	10	4	20
15	Psychological—								
	a. Development	2	12	—	9	2	31	4	52
	b. Stability	2	43	—	11	4	58	6	112
16	Abdomen	—	7	1	6	1	14	2	27
17	Other	37	46	11	33	7	74	55	153

TABLE B.—SPECIAL INSPECTIONS.

Defect Code No. (1)	Defect or Disease (2)	Special Inspections	
		Pupils requiring Treatment (3)	Pupils requiring Observation (4)
4	Skin	8	5
5	Eyes—		
	a. Vision	57	11
	b. Squint	2	2
	c. Other	11	3
6	Ears—		
	a. Hearing	3	4
	b. Otitis Media	2	1
	c. Other	2	—
7	Nose and Throat	10	13
8	Speech	10	1
9	Lymphatic Glands	1	3
10	Heart	—	1
11	Lungs	3	6
12	Developmental		
	a. Hernia	1	—
	b. Other	—	1
13	Orthopaedic—		
	a. Posture	18	4
	b. Feet	17	2
	c. Other	5	4
14	Nervous System—		
	a Epilepsy	—	—
	b. Other	—	1
15	Psychological—		
	a. Development	7	6
	b. Stability	—	13
16	Abdomen	—	3
17	Other	13	14

PART III. TREATMENT OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING NURSERY AND SPECIAL SCHOOLS).

TABLE A.—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

	Number of cases known to have been dealt with
External and other, excluding errors of refraction and squint	34
Errors of refraction (including squint)	532
Total	566
Number of pupils for whom spectacles were prescribed	430

TABLE B.—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

	Number of cases known to have been dealt with
Received operative treatment—	
(a) for diseases of the ear	16
(b) for adenoids and chronic tonsillitis	254
(c) for other nose and throat conditions	16
Received other forms of treatment	4
Total	290
Total number of pupils in schools who are known to have been provided with hearing aids—	
(a) in 1960	3
(b) in previous years	9

TABLE C.—ORTHOPAEDIC AND POSTURAL DEFECTS.

	Number of cases known to have been treated
(a) Pupils treated at clinics or out-patients departments	31
(b) Pupils treated at school for postural defects	327
Total	358

TABLE D.—DISEASES OF THE SKIN.

(excluding uncleanliness, for which see Table D of Part I)

	Number of cases known to have been treated
Ringworm— (a) Scalp	—
(b) Body	—
Scabies	8
Impetigo	2
Other skin diseases	64
Total	74

TABLE E.—CHILD GUIDANCE TREATMENT.

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	120

TABLE F.—SPEECH THERAPY.

	Number of cases known to have been treated
Pupils treated by speech therapists	176

TABLE G.—OTHER TREATMENT GIVEN.

(a) Pupils with minor ailments	563
(b) Pupils who received convalescent treatment under School Health Service arrangements	—
(c) Pupils who received B.C.G. vaccination	2682
(d) Other than (a), (b) and (c) above— Please specify	—
Total (a)—(d)	3245

PART IV. DENTAL INSPECTION AND TREATMENT CARRIED OUT BY THE AUTHORITY.

(1) Number of pupils inspected by the Authority's Dental Officers:—	
(a) At Periodic Inspections	5575
(b) As Specials	1374
Total (1)	6949
(2) Number found to require treatment	5511
(3) Number offered treatment	4872
(4) Number actually treated	3338
(5) Number of attendances made by pupils for treatment, including those recorded at 11(h)	5709
(6) Half days devoted to:	
(a) Periodic (School) Inspection	58
(b) Treatment	1289
Total (6)	1347

(7) Fillings:	
(a) Permanent Teeth	3551
(b) Temporary Teeth	121
Total (7)	3672
(8) Number of Teeth filled:	
(a) Permanent Teeth	3076
(b) Temporary Teeth	117
Total (8)	3193
(9) Extractions:	
(a) Permanent Teeth	839
(b) Temporary Teeth	3040
Total (9)	3879
(10) Administration of general anaesthetics for extraction	1191
(11) Orthodontics:	
(a) Cases commenced during the year	43
(b) Cases brought forward from previous year	38
(c) Cases completed during the year	45
(d) Cases discontinued during the year	3
(e) Pupils treated by means of appliances	43
(f) Removable appliances fitted	46
(g) Fixed appliances fitted	113
(h) Total attendances	821
(12) Number of pupils supplied with artificial teeth	22
(13) Other operations:	
(a) Permanent Teeth	651
(b) Temporary Teeth	108
Total (13)	759

APPENDIX III

DIET SHEETS

(see Page 14)

(These diet sheets were prepared by Miss M. H. Chivers, Dietitian Catering Officer, Addenbrooke's Hospital, to whom acknowledgment is made.)

Where it is thought that a child will benefit by dieting the parent is issued with (a), and either (b) OR (c).

(a) **You may have the following:**

Meat:	including beef, lean boiled bacon or ham, chicken, heart (no fat), kidney, lamb, liver, mutton, rabbit, salt beef, veal, tripe.
Fish:	including haddock (fresh or smoked), cod, plaice, sole, hake, halibut, herring, kippers, bloaters, salmon (fresh or tinned), sardines (drained of oil), pilchards (drained of oil) prawns, shrimps, trout.
Vegetables:	green or root variety—see diet sheet.
Salads:	lettuce, tomato, cucumber, radishes, cress, onions.
Fruit:	fresh or stewed without sugar—sweetened with saccharine or Saxin if desired. Not more than 3 portions daily.
Relishes:	pickles in vinegar, Worcester sauce, vinegar, pepper, salt, mustard.
Miscellaneous:	tea, coffee, soda-water, water.
Milk:	not more than ½ pint daily.
Butter or Margarine:	not more than ¾ oz. daily.
Bread:	not more than stated on diet sheet.

You may not have:

Fried foods of any description.

Sugar, glucose, jam, marmalade, honey, syrup, chocolates, sweets, ice-cream, jellies, cream, cocoa, malted milk drinks, sweetened fruit drinks, cakes, pastries, puddings, cereals, biscuits.

Tinned fruit in syrup, dried fruits, grapes, bananas, nuts, baked beans, spaghetti.

Oil and salad dressing.

Flour, cornflour, custard powder.

(b) **Low Calorie Diet** (1,000 Calories)

Breakfast:	Tea with milk, Saxin or saccharine if desired, NO SUGAR. Grapefruit or fresh fruit. Tomato. 1 Egg OR *lean* grilled bacon OR fish. 1½ thin slices of brown bread. Scraping butter or margarine. NO marmalade, honey, syrup.
Mid-morning:	1 apple or orange or pear.
Dinner:	Average helping of lean meat, fish (NOT fried), poultry, rabbit or liver. NO thickened sauces. Green vegetables:—cabbage, cauliflower, spinach, marrow, runner beans, french beans, celery, brussel sprouts. Turnips, swedes. As desired. Other vegetables:—carrots, parsnips, peas—small helping (not more than one tablespoonful) OR 1 tablespoonful potato. Salads as desired (no salad cream or oil). Fruit—fresh or stewed without sugar (saccharine or Saxin if desired).
Tea:	Tea with milk—NO SUGAR. 1 thin slice of brown bread. Scraping of butter or margarine. Meat or vegetable extract (e.g. Marmite), tomato, lettuce, cucumber.
Supper:	Average helping of lean meat or fish or cheese or egg. Salad or green vegetables as at dinner. 1½ thin slices brown bread. Scraping of butter or margarine. Fresh fruit if not eaten at breakfast. Tea or coffee with milk—NO SUGAR.

(c) **Low Calorie Diet** (1,500 Calories)

Breakfast:	Tea with milk—NO SUGAR. Saccharine or Saxin if desired. Grapefruit, fresh fruit, tomato. Egg OR *lean* grilled bacon OR fish. 2 thin slices of brown bread. Scraping butter or margarine. NO marmalade, honey, syrup.
Mid-morning:	1 apple, or orange or pear.
Dinner:	Generous portion of *lean* meat, fish (not fried). Poultry, offal, etc. No thickened sauces. Green vegetables—cabbage, cauliflower, spinach, marrow, runner beans, fresh beans, celery, brussel sprouts. Turnips. swedes. As desired. Other vegetables—carrots, parsnips, pears (not more than 2 tablespoonsful) OR 2 tablespoonsful of potato. Salads as desired (no salad cream or oil). Fruit—fresh or stewed without sugar (saccharine or Saxin if desired).
Tea:	Tea with milk—NO SUGAR. 2 thin slices of brown bread. Scraping of butter or margarine. Meat or vegetable extract (e.g. Marmite), tomato, lettuce, cucumber.
Supper:	Generous portion of *lean* meat, fish, cheese or egg. Salad or green vegetables as at dinner. 2 thin slices of brown bread. Scraping of butter or margarine. Fresh fruit if not eaten at breakfast. Tea or coffee with milk—NO SUGAR.

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